

CERTIFICATE OF DEATH

01439

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 Mc Cormick Avenue</u>		d. STREET ADDRESS <u>22 Mc Cormick Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Howard Allard</u>		4. DATE OF DEATH <u>February 17th 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Allard</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-6814</u>	
17. INFORMANT <u>Mrs. Elizabeth M. Allard</u>		Address <u>22 Mc Cormick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> (LESS THAN 24 HOURS) <u>UNKNOWN</u> (SEVERAL YEARS)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>57</u> , to <u>2/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert C. Herrmann</u> M.D.		ADDRESS (Street, city or town, state) <u>4420 MANNASOTA AVE. BALTO 6, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT C. HERRMANN, M.D.</u>		DATE SIGNED <u>2/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mareland Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>	

# CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01440  
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md.		b. COUNTY Baltimore	
c. LENGTH OF STAY IN TB July, 1956		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1901 Lawn Meadow Ave.		d. STREET ADDRESS 1507 N. Monroe St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Alston		4. DATE OF DEATH Month Day Year Feb. 23 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1919
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11b. KIND OF BUSINESS OR INDUSTRY Housework	
11c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Richardson		14. MOTHER'S MAIDEN NAME Esther Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-22-8940	
17. INFORMANT Esther McCargo, 413 N. Vincent St., Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C-V Disease 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr. ? 2 yr. ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 2-25-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Joseph A. Lively, 661 W. Barre St. Balto., Md.		24a. REC'D BY REGISTRAR DATE 2-25-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Shue	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER & CERTIFICATE OF DEATH

BUREAU V. 3

FEB 27 1957

RECEIVED



1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stockton Road</u>		d. STREET ADDRESS <u>Stockton, Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. John R. Amos, Jr.</u>		4. DATE OF DEATH <u>February 7th</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>17</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Amos, Sr</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1927 York Rd, TIMONIVY</u>	
17. INFORMANT <u>Mrs. Agnes L. Amos, Stockton Rd. Phoenix</u>		Address <u>Phoenix</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>443X</u> DUE TO (c) <u>443X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 12<sup>th</sup>, 1956</u> , to <u>Feb 6<sup>th</sup>, 1957</u> , that I last saw the deceased alive on <u>Feb 6<sup>th</sup>, 1957</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. X. Quinn</u>		ADDRESS (Street, city or town, state) <u>1927 York Rd, TIMONIVY</u>	
PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN</u>		DATE SIGNED <u>2-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Ruck</u>		ADDRESS <u>5305 Harford Road.</u>	
24a. REC'D BY REGISTRAR <u>2-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Ely. Horan</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

PRE-EXISTING INJURY

PRE-EXISTING WEAKNESS

PRE-EXISTING DEFECT

PRE-EXISTING DISORDER

PRE-EXISTING CONDITION

PRE-EXISTING STATE

PRE-EXISTING SITUATION

PRE-EXISTING CIRCUMSTANCE

PRE-EXISTING FACTOR

PRE-EXISTING ELEMENT

PRE-EXISTING PART

PRE-EXISTING COMPONENT

PRE-EXISTING ASPECT

PRE-EXISTING CHARACTER

PRE-EXISTING QUALITY

PRE-EXISTING QUANTITY

PRE-EXISTING MEASURE

PRE-EXISTING DEGREE

PRE-EXISTING RATIO

PRE-EXISTING PROPORTION

PRE-EXISTING PERCENTAGE

PRE-EXISTING FRACTION

PRE-EXISTING DECIMAL

PRE-EXISTING SIGN

PRE-EXISTING SYMBOL

PRE-EXISTING MARK

PRE-EXISTING SIGNATURE

BUREAU V. 1

SEP 14 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Marriottsville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>	c. LENGTH OF STAY IN 1b <b>2 Weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1904</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labourer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Harvey Anderson</b>	14. MOTHER'S MAIDEN NAME <b>Rosie Collins</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>	17. INFORMANT <b>Shane E. Anderson - Beltsville, Md.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive incineration of body</b> DUE TO <b>916.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration of house</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>Feb. 20, 57</b> p. m. <b>0</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Marriottsville</b>		(County) _____ (State) <b>Maryland</b>

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>2/20/57</b>
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>2-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Anderson Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Beltsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Harry Allen</b>		24a. REC'D BY REGISTRAR DATE <b>2-23-57</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. Marton</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be ordered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 1 1957  
BUREAU T. H.

1446

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN IB <b>33 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1908 Druid Hill Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L.</b> Last <b>ANDERSON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25, 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teamster</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Horse Racing</b>		11. BIRTHPLACE (State or foreign country) <b>Charlottesville, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Carry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>225-24-3332</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH GENERALIZED METASTASES</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right hydrocele, testicular</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 2, 19 57</b> to <b>February 4, 19 57</b> and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2/5/57</b>							
ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, M.D. VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Chas. R. Law Mortuary, 802-Oh Madison Ave., Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>Feb. 1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Tawson L. Farber</b>	



CERTIFICATE OF DEATH

1956

BUREAU V. S.

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 FilmG.11 2-10-57 et.

01444

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oakland Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Anderson</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1871</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	11. BIRTHPLACE (State or foreign country) <b>Ireland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William Anderson</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Welfare Records, Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC C.V. DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b> <b>YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/21</b> , 1957, to <b>2/25</b> , 1957, that I last saw the deceased alive on <b>2/21</b> , 1957, and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. F. Eline &amp; Sons</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>48 Main St. Reisterstown Md. 2/25/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 27/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2-25-57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>

BUREAU V. S.

FEB

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01445

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>				c. LENGTH OF STAY IN 1b <b>x2 Timonium</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Belfast Road</b>				d. STREET ADDRESS <b>Belfast Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Betty Jane Annegan</b> Middle Last				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1911</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alonzo Cole</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frank Annegan, Timonium, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (c) <b>5 yrs</b> DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Feb. 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>McGlumphy Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksburg, W. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>				ADDRESS <b>Towson, Maryland</b>		24a. REG'D BY REGISTRAR <b>Feb. 22, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 26 1957

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapman Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fluence</u> Middle <u>Lenore</u> Last <u>Barr</u>		4. DATE OF DEATH <u>February 5</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1922</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Joseph Skliar</u>		14. MOTHER'S MAIDEN NAME <u>Ella Newman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Irwin R. Barr - Chapman Rd., Kingsville, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Cerebrum</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-5</u> Hour <u>2</u> a. m. <u>5</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Kingsville</u> (County) <u>Baltimore</u> (State) <u>Md</u>	
21. Certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-5-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto, Hebrew Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm F. Lickner &amp; Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>Dr. H. Hammett</u>	
ADDRESS <u>  </u>		DATE <u>2-6-57</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

FEB 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01447
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 40
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyde (rural)</b>			c. LENGTH OF STAY IN 1b <b>5yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyde (rural)</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Manor Rd.</b>					d. STREET ADDRESS <b>Manor Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert Bell</b>					4. DATE OF DEATH Month Day Year <b>2-11-57 19</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-15-1887</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Sandy Bell</b>					14. MOTHER'S MAIDEN NAME <b>Henrietta ?</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War I 214-22-5975</b>		17. INFORMANT <b>Janie Bell</b>		Address <b>Hyde, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Living in small shack on a farm. It caught on fire - reason unknown - and burned to ground. Bell's almost completely burned.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Balto. Md.</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>2/11/57</b>
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>2-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Scott Brooks</b>					ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>Dr. Helter L. Smith</b>		24b. REGISTRAR'S SIGNATURE	

RECEIVED V. E.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remain carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01448

1451

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 N. Beechwood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>ELLEN</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>24</b> Hours <b>19</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Thurmont, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry W. Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Ellen Rhodes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Nellie Bennett-302 N. Beechwood Avenue #28</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis with Hemiplegia left</b> DUE TO <b>Chronic congestive heart failure with anasarca</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 months</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jan 57</b>		20f. (City or town) <b>Feb 24 1957</b> (County) (State)	
21. I certify that I attended the deceased from <b>Jan 57</b> , 19, to <b>Feb 24 1957</b> , 19, that I last saw the deceased alive on <b>24 Feb 1957</b> , and that death occurred at <b>2:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. McGrath M.D.</b>		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 Md</b>	
DATE SIGNED <b>2/24/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Becker - Home - North &amp; Park Ave</b>		24a. REC'D BY REGISTRAR <b>2557</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. E. McGrath</b>	

MEDICAL CERTIFICATION



BUREAU V. S.

FEB 23 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>md</b> b. COUNTY <b>Balti</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
c. LENGTH OF STAY IN lb <b>3 yr</b>		d. STREET ADDRESS <b>107 Helrey Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Helrey Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDNA CARROLL BENSON</b>		4. DATE OF DEATH <b>Feb 5 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 12, 1918</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Benjamin T. Bealer</b>	
14. MOTHER'S MAIDEN NAME <b>Lida E. Kroll</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>72000</b>		17. INFORMANT <b>Bernard T. Benson</b> Address <b>107 Helrey Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast, Left</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>170X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan. 1949</b> , to <b>Feb. 5, 1957</b> , that I last saw the deceased alive on <b>Feb. 5, 1957</b> , and that death occurred at <b>9:45 P. M.</b> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <b>601 Mellow Hill Ave., Baltimore, Md</b>		DATE SIGNED <b>2/6/57</b>	
ACTUAL SIGNATURE <b>Leo J. Geyer</b>		PHYSICIAN'S NAME (Type) <b>Leo J. Geyer, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 8/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balti Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Kuhl</b> ADDRESS <b>5311 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 7 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Outward</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 7 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1455

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>White Hall</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Openshaw Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>White Hall P.O.</b> d. STREET ADDRESS <b>Openshaw Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Edgar Bishop</b>				4. DATE OF DEATH Month Day Year <b>March Feb. 28 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1929</b>	
9. AGE (in years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edgar A. Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Christine A. Harmony</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-22-0889</b>		17. INFORMANT <b>Personal Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> <b>773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>A. M. France</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/3/57</b>	
EXAMINER'S NAME (Type) <b>A. M. France</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sater's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lutherville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>				ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>5 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chester L. Lutton</b>			

U. S. A. 1914

1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01451

1454

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Euthersville,</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor</b>		d. STREET ADDRESS <b>Greenway Apartments</b>	
3. NAME OF DECEASED (Type or print) First <b>Sara</b> Middle <b>Macneal</b> Last <b>Blatter</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James B. Macneal</b>		14. MOTHER'S MAIDEN NAME <b>Sara Mann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. N. Herbert Long</b>		Address <b>3908 Canterbury Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>Arterio-sclerous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>myocarditis</b> DUE TO <b>hypertension</b> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs</b> <b>Gradual</b> <b>"</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1947</b> , to <b>Feb 8 1957</b> , that I last saw the deceased alive on <b>Feb 8, 1957</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Woody</b>		M.D. <b>Baltimore Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. W. H. Woody</b>		ADDRESS (Street, city or town, state) <b>1403 Park Ave.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR <b>FEB 11 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Woody</b>	

BUREAU V. S.

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RECEIVED

1455

CERTIFICATE OF DEATH

01452

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7813 Tilmont Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. John Joseph Blessing</i>				4. DATE OF DEATH <i>February 9th 19 57</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 3, 1874</i>	
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Fireman</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Blessing</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Guckey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Charles Liebmann, 7813 Tilmont Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO <i>Generalized Arteriosclerosis and</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Degenerative process &amp; age</i> (b) <i></i> (c) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pernicious Anemia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Baltimore</i> (County) <i></i> (State) <i></i>							
21. I certify that I attended the deceased from <i>Jan 1955</i> , 19 <i>55</i> , to <i>Feb 9</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb 9</i> , 19 <i>57</i> , and that death occurred at <i>10:45</i> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F.T. Kasik, Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>9005 Harford Rd., Baltimore</i>			
F. T. Kasik, Jr., M.D.				DATE SIGNED <i>2/9/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/12/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>				24a. REC'D BY REGISTRAR <i>FEB 13 1957</i>		24b. REGISTRAR'S SIGNATURE <i>A. M. Bacon</i>	

BUREAU V. S.

FEB 1 1957

RECEIVED

1456

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr3mth14dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOS'ITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Blickenstaff</b> Last <b>Blickenstaff</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Rubin</b>		14. MOTHER'S MAIDEN NAME <b>Annie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> o. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 12, 1957</b> , to <b>Feb. 13, 1957</b> , that I last saw the deceased alive on <b>Feb. 13, 1957</b> , and that death occurred at <b>4:25 p.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-13-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		Address <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/16/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CHESTNUT GROVE Church</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Co MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WAS F. EVANS + Son</b>		ADDRESS <b>118 W. MT. Royal Ave</b>	
24a. REC'D BY REGISTRAR <b>FEB 18 57</b>		24b. REGISTRAR'S SIGNATURE <b>Quil...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

13

DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1457

## CERTIFICATE OF DEATH

01454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>SALLIE - I - BORING</u>		4. DATE OF DEATH <u>Feb 6 - 1957</u> 19	
5. SEX <u>FA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12 - 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Price</u>		14. MOTHER'S MAIDEN NAME <u>Lucinia Klinedinst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>B. W. Boring</u>		Address <u>Boring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-Sclerosis</u> (c) <u>Congestive Heart Failure (Arterio-Sclerotic)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1956</u> , to <u>Feb. 6, 1957</u> , 19, that I last saw the deceased alive on <u>Feb. 5, 1957</u> , and that death occurred at <u>2:05 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>2-6-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-9-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lownd Ridges</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Lipton - Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 2-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B Elmer</u>	

BUREAU A 3

FEB 11 1957

RECEIVED



# CERTIFICATE OF DEATH

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12 (Rogers Forge)</b>		c. LENGTH OF STAY IN 1b <b>12 (Rogers Forge)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Murdock Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>DENNIS</b> Middle <b>TALBERT</b> Last <b>BUCKINGHAM</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1890</b>		9. AGE (In years last birthday) yrs. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pillsbury Mills</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Dennis Talbert Buckingham, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Maude Shauck</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-07-1570</b>		17. INFORMANT <b>Family Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas &amp; Liver</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <b>July 20, 1956</b> , to <b>Sept 1, 1957</b> , that I last saw the deceased alive on <b>Sept 1, 1957</b> , and that death occurred at <b>7:50 AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md,</b>		DATE SIGNED _____			
ACTUAL SIGNATURE <b>Laurence C. Post</b>		M.D. <b>6805 York Rd</b>		PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garber, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>David Bankard, Westminster, Maryland</b>		24a. REC'D BY REGISTRAR <b>Feb 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

BUREAU V. S.

FEB 4 1957

RECEIVED

## 1459 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>88 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1357 N. Fremont Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY R. BURKE</b>				4. DATE OF DEATH Month Day Year <b>February 12 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 21, 1907</b>	
9. AGE (In years last birthday) yrs. <b>49</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>12 19 57</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bottling Business</b>			
11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co., Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Albert Burke</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Stepheny</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		(If yes, give year or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>213-03-4872</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG, LEFT UPPER LOBE WITH GENERALIZED METASTASIS</b> 163X <del>XXXX</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ABSCCESS, LEFT UPPER LOBE</b> (c) <b>PULMONARY EDEMA, BILATERAL</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <b>VA</b> attended the deceased from <b>November 16, 1956</b> , to <b>February 12, 19 57</b> , that I last saw the deceased <b>XXXXXX</b> and that death occurred at <b>8:30P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>ROLANDO D. PONCE de LEON</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>2/13/57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, M.D., VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George G. Nelson</b>				ADDRESS <b>1348 N. Calhoun St., Balto. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2/14/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. Dawson, L. Harber</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

NEW

1460

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Lancaster</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Branch St.</b>		d. STREET ADDRESS <b>523 W. Mary St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Jean</b> Middle <b>Mulholland</b> Last <b>Byerly</b>		4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/01</b>
9. AGE (In years last birthday) yrs. <b>55</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Belfast, Ireland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Mulholland</b>	
14. MOTHER'S MAIDEN NAME <b>Ann E. Platt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Norman E. Byerly</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>163 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of lung</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 24, 1956</b> to <b>Feb 22, 1957</b> that I last saw the deceased alive on <b>Feb 21, 1957</b> , and that death occurred at <b>5:45</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. L. Kolodny, MD</b>		ADDRESS (Street, city or town, state) <b>1825 Eastern Blvd Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. L. Kolodny, MD</b>		DATE SIGNED <b>2/22/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2/24/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lancaster, Co. Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Brzezinski</b>		24a. REC'D BY REGISTRAR <b>DATE 2/22/7</b>	24b. REGISTRAR'S SIGNATURE <b>Earl Hurley</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 26 1977  
BUREAU V. S.

1461

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pikesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3903 Buckingham Road</b>				d. STREET ADDRESS <b>3903 Buckingham Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Olevia</b> Middle <b>M.</b> Last <b>Byrd</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1976</b>		9. AGE (In years last birthday) yrs. <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Getwicks</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Rumberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <b>William E. Byrd, 7920 Seabreeze Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Hypertensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease.</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>7-8 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. p.</b> <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>Dec 27, 1956</b> to <b>Feb 3, 1957</b> , that I last saw the deceased alive on <b>Feb 3, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph E. Muse Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>5 West 29th Street</b> DATE SIGNED <b>4 Feb 57</b>			
PHYSICIAN'S NAME (Type) <b>Joseph E. Muse, Jr. M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. RECEIVED BY REGISTRAR <b>FEB 5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lorothy Newell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K. 3

FEB 2

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1462

## CERTIFICATE OF DEATH

## 01459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3mths 5yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1210 Cox Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ruth P. Caldwell</b>				4. DATE OF DEATH Month Day Year <b>February 22, 19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1898</b>	9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Pulse</b>				14. MOTHER'S MAIDEN NAME <b>Eva Worster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>217-09-1847</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>416x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Chronic, rheumatic heart disease</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Feb. 1</b> , 19 <b>57</b> , to <b>Feb. 22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 22</b> , 19 <b>57</b> , and that death occurred at <b>6:20a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				DATE SIGNED <b>2-22-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home, 3631 Falls Road,</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 25 57</b>		24b. REGISTRAR'S SIGNATURE <b>Horace F. Burgee</b>	

RECEIVED

FEB 27 1954

BUREAU V. 2

Reg. Dist. No. 01460

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN TB <u>70yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Roxville Rd.</u>		d. STREET ADDRESS <u>Roxville Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Eugene Calp.</u>		4. DATE OF DEATH Month Day Year <u>February 18, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Canning Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beckleysville, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Calp.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rhoeback</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>198-104348</u>	
17. INFORMANT <u>John Calp., Parkton, Md. R.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, essential</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>2-16-1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-16-</u> , 19 <u>55</u> , to <u>2-15-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-15-</u> , 19 <u>57</u> , and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson,</u>		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>R. ROBINSON, M.D.</u>		DATE SIGNED <u>2/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beckleysville, Balt. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Charles J. Fulton</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>	

BUREAU V. S.

FEB 25 1957

RECEIVED

# CERTIFICATE OF DEATH

01461

Reg. Dist. No.

MEDICAL CERTIFICATIONVS AIS (4)  
ISM 9/SS

RECEIVED  
FEB 27 1961  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1465

## CERTIFICATE OF DEATH

### 01462

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7807 Oakdale Avenue</u>				d. STREET ADDRESS <u>7867 Oakdale Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. William T. Carter Sr.</u>				4. DATE OF DEATH Month Day Year <u>February 5th 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 28, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Carter</u>				14. MOTHER'S MAIDEN NAME <u>Jane Warfel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-6016</u>		17. INFORMANT Address <u>Mrs. Nannie M. Carter, 7867 Oakdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Lung (Right)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>56</u> , to <u>2/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H. D. + V. N. C. L. I.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>21 / 11957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard G. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Anley</u>	

C

BUREAU V. 2

FEB 13 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1466

CERTIFICATE OF DEATH

01463 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>71 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WINFIELD</b> Middle <b>R.</b> Last <b>CHESTER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1889</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William H. Chester</b>		14. MOTHER'S MAIDEN NAME <b>Mary Keys</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>150x</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 2, 1956</b> , to <b>February 11, 1957</b> , that I saw the deceased on <b>February 11, 1957</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 2/12/57</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND 2/12/57</b>			
PRINTED NAME (Type) <b>IRVING FREEMAN, Chief, Medical Service, VAH, Ft. Howard, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808 N. Monroe St. Balto. Md.</b>	
24a. REC'D BY REGISTRAR <b>2-13-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNN V. S.

RECEIVED  
JAN 10 1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01464 *44*

1467

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>19 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>114 Garrett Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES H. CHRISTNER</b>				4. DATE OF DEATH Month Day Year <b>February 13 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1892</b>	9. AGE (in years last birthday) yrs. <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Brownsville, Pennsylvania</b>	
13. FATHER'S NAME <b>Frank G. Christner</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19 1:30 PM</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8:30 AM</b>		20f. (City or town) (County) (State) <b>VA</b>	
21. I certify that I attended the deceased from <b>February 12, 19 57</b> , to <b>February 13, 19 57</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Irving Freeman</i> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				DATE SIGNED <b>2/13/57</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Redstone Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fayette County, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Gook-Blight, Inc.</i> <b>Wm. Gook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>2-18-57</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	

U.S. AIR FORCE

1957

RECEIVED

1468

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home</b>				d. STREET ADDRESS <b>2708 Huntingdon Ave.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>L.</b> Last <b>Cochran</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>17,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 18, 1887</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. &amp; Pa. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cochran</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-10-8810</b>		17. INFORMANT <b>Mrs. Mary T. Cochran</b> Address <b>2708 Huntingdon Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Chs. Hypertensive Cardiac-Vascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>1037(?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-15</b> , 1957, to <b>2-17</b> , 1957, that I last saw the deceased alive on <b>2-16</b> , 1957, and that death occurred at <b>9:58 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Ave.</b> DATE SIGNED <b>2-18-57</b> ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b> M.D. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, M.D.</b> <b>Catonsville-28, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-20-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Long Green, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b> ADDRESS <b>3607 W. North Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>2/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1957

RECEIVED

1469

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTHEAST, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD TRAINING SCHOOL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>PAUL</u> Last <u>CONNERS</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-30</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>EKTON, CECIL CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>William Paul Connors Sr.</u>		14. MOTHER'S MAIDEN NAME <u>ANNA FRANKLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (FATHER) <u>William Paul Connors</u>		Address <u>NORTHEAST, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO - PNEUMONIA</u> DUE TO (b) <u>CEREBRAL SPASTIC, INFANTILE PARALYSIS</u> DUE TO (c) <u>EPILEPSY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS - BIRTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 16</u> , 19 <u>57</u> , to <u>FEB. 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11:30 pm, 2-16</u> , 19 <u>57</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. Butler</u>		DATE SIGNED <u>Feb 19 1957</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		ADDRESS (Street, city or town, state) <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary Anne</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Clines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1967

1967

DEPT. OF THE ARMY



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01467

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b>		c. LENGTH OF STAY IN 1b <b>50yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2601 Cub Hill Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>GUY</b> Middle <b>Franklin</b> Last <b>COOK</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>18</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>Edinburg Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Cook</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>216-12-6949</b>	
17. INFORMANT <b>Mrs. Marie C. Cook</b>		Address <b>2535 Greenmount Ave. 18</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b>			
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. J. M. Bacon</b>		ADDRESS <b>2024 Orleans St. 31</b>	
24a. REC'D BY REGISTRAR <b>DATE 2-13-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

U. S. A. 1934

1934

1934

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G211 2-20-57 et

## CERTIFICATE OF DEATH

01468

Reg. Dist. No.

Item 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2530 Hillcrest Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Mary Elizabeth Corcoran</u>		4. DATE OF DEATH Month Day Year <u>February 8th 19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887 Oct. 6, 1887</u>
9. AGE (In years last birthday) <u>70 6/7 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Birchenough</u>		14. MOTHER'S MAIDEN NAME <u>Martha Chadwick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Joseph Edward Corcoran, Hillcrest Av</u>		Address <u>2530</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastasis</u> DUE TO (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>metastasis</u> DUE TO (d) <u>metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> , 19____, to <u>2-8-57</u> , 19____, that I last saw the deceased alive on <u>2-7-57</u> , 19____, and that death occurred at <u>12:39 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. V. Rangle M.D.</u> M.D. <u>2-9-57</u>		DATE SIGNED <u>2-8-57</u>	
PHYSICIAN'S NAME (Type) <u>R. V. Rangle M.D.</u>		ADDRESS (Street, city or town, state) <u>Bulk. 18, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/13/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Paterson, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hargord Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>2-13-57</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Baranov</u>

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shadybrook Convalescent Home</u>		d. STREET ADDRESS <u>1002 N. Rolling Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret E. Coughlan</u>		4. DATE OF DEATH <u>Feb 6 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Goldstein Bros</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Coughlan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Elizabeth B. E. Echart</u>		Address <u>818 Mt Holly St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 m -</u> <u>years</u> <u>years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocarditis severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1956</u> to <u>Feb 6 1957</u> that I last saw the deceased alive on <u>Feb 4 1957</u> and that death occurred at <u>11:57 AM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W. H. D. Fort</u> M.D. <u>1118 St. Paul St.</u>		PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u> <u>1118 St. Paul St. Balt. 2</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 E. D. Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		ADDRESS <u>961 Hollins St.</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 8 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. D. Fort</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FINLEY V. B.

187

187

1473

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1723 Joppa Road</b>		d. STREET ADDRESS <b>1723 Joppa Road</b>	
3. NAME OF DECEASED (Type or print) <b>NETTIE JANE COX</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1874</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ephriam B. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Susan C. Prim</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JANUARY, 1954</b> , to <b>February 1957</b> , that I last saw the deceased alive on <b>December 13, 1956</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. X. Quinn</b> M.D. <b>1927 York Rd. TOWSON, MD.</b>		DATE SIGNED <b>Feb. 12, 1957</b>	
PHYSICIAN'S NAME (Type) <b>M. KEVIN QUINN</b>		Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 13, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Freeland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		24a. REG'D BY REGISTRAR <b>Feb. 12, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1957

100-100000



1474

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Warren Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Alberta Curtis</b>		4. DATE OF DEATH Month Day Year <b>2-10-57</b> 19	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-1867</b>
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Williams</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Wm. Harrison Curtis, Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1949</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October, 1956</b> , to <b>Feb. 8<sup>th</sup>, 1957</b> , that I last saw the deceased alive on <b>Feb. 8<sup>th</sup>, 1957</b> , and that death occurred at <b>6:30 p. m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. K. Quinn</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1927 YORK Rd TIMONIUM, Md. 2-11-57</b>	
PHYSICIAN'S NAME (Type) <b>M. KEVIN QUINN MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-13-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Scott Brooks</b>		ADDRESS <b>Towson 4, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 2/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Chishead</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01472

1475

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>234 Glenmore Ave</b>		e. STREET ADDRESS <b>Montgomery Rd, Elkridge Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>M.</b> Last <b>Devan</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher, Balto. City</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Devan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kyne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Martha Devan, Elkridge Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Atherosclerosis, generalized, severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-4</b> , 19 <b>57</b> to <b>2-6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-6</b> , 19 <b>57</b> , and that death occurred at <b>9:15 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen Lee Magness</b> M.D.		ADDRESS (Street, city or town, State) <b>908 Frederick Rd, Catonsville</b>	
PHYSICIAN'S NAME (Type) <b>STEPHEN LEE MAGNESS</b>		DATE SIGNED <b>2-8-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 9/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Augustine Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b>		24a. REC'D BY REGISTRAR <b>Feb 11 57</b>	
ADDRESS <b>4101 Edmondson Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

BUREAU V. S.

FEB 11 1901

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1 and 2 should be filed with the Registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01473

1476

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8319 LIBERTY ROAD</u>		d. STREET ADDRESS <u>8319 LIBERTY ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>MARION</u> Last <u>DIGGINS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CREDIT MGR.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>CORNELIUS J. DIGGINS</u>		14. MOTHER'S MAIDEN NAME <u>HENORIA CUSHING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. PAUL DIGGINS - 8319 LIBERTY RD. BALTO. MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA RECTUM &amp; GENITALIA.</u> <u>154X</u> DUE TO <u>CARCINOMATOSIS -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>12. X</u> (b) <u>CEREBRAL VASCULAR ACCIDENT &amp; PARALYSIS</u> (c) <u>HYPERTENSIVE C.V. DISEASE - SEVERE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>7 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE C.V. DISEASE - SEVERE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1, 1956</u> , to <u>FEB. 2, 1957</u> , that I last saw the deceased alive on <u>FEB. 2, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler M.D.</u>		ADDRESS (Street, city or town, state) <u>3601 Capmark Rd - BALTO 7 - MD</u>	
DATE SIGNED <u>2/2/57</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Vernon Lemmon</u>		ADDRESS <u>4611 Park Heights Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. Masten</u>	

BUREAU Y. S.

1957

RECEIVED

1477

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MD.</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>P</b> Last Sr. <b>DOORY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/23/95</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Doory</b>		14. MOTHER'S MAIDEN NAME <b>Annie Proctor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-05-4550</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA LEFT UPPER LOBE &amp; RIGHT MIDDLE AND LOWER LOBES</b> DUE TO <b>11X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ADVANCED EMPHYSEMA OF LUNG, BILATERAL</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>February 2, 1957</b> , to <b>February 9, 1957</b> , that I last saw the deceased alive on <b>February 9, 1957</b> , and that death occurred at <b>4:20 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b> M.D. <b>VAH, Fort Howard, Maryland</b> <b>2/10/57</b> PERSON'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 13, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, 2601 E. Madison St</b> <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2-13-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisher</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINNA V. E.

1881 FEB 1

1881 FEB 1



1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>27 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>DORSEY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1890</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Parole, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Tydings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clin. Rec. Vet. Administration Hospital, Ft. Howard, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER</b> DUE TO <b>HEMOCHROMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>6 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 10, 1957</b> to <b>February 6, 1957</b> and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/7/57</b> ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b> M.D. PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis, National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese Funeral Home</b>				ADDRESS <b>Washington St., Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>B 16 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farkes</b>			

BUREAU V. S.

FEB

RECEIVED

1479

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1901 Summit Ave.</b>				d. STREET ADDRESS <b>1901 Summit Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>KUNIGUNDA DRUMMER</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>16</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 27, 1867</b>	
9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>? ALT</b>				14. MOTHER'S MAIDEN NAME <b>? ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>William L. Drummer</b> Address <b>1901 Summit Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis C.V.D.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>30 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>2/11, 1957</b> , to <b>2/16, 1957</b> , that I last saw the deceased alive on <b>2/15, 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>D. J. Battaglia</b> M.D. <b>5829 Belair Rd</b> <b>2/18/57</b> PHYSICIAN'S NAME (Type) <b>Dr. D.T. Battaglia</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b> ADDRESS <b>3000 E. Baltimore St.</b>				24a. REC'D BY REGISTRAR <b>Edith H. Hays</b>		24b. REGISTRAR'S SIGNATURE <b>Edith H. Hays</b>	

RECEIVED

FEB 20 1957

BUREAU W. A.

## 1480 CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1114 ROSEDALE AVE.</u>		d. STREET ADDRESS <u>1114 ROSEDALE AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>JENNY</u> Last <u>DUTTERER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NOAH HOLLINGER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET KAUFFMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>John W. Dutcher</u>		Address <u>1114 Rosedale Ave. #6, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>45 HOURS</u> <u>10 YEARS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>53</u> , to <u>FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 19</u> , 19 <u>57</u> , and that death occurred at <u>2:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>James R. Mason</u> M.D.		DATE SIGNED <u>FEB 21 1957</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MASON</u>		ADDRESS <u>BALTIMORE 6, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S - CEM. SILVER POIN</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>		24a. REC'D BY REGISTRAR <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01478

1481

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28,</b>		c. LENGTH OF STAY IN 1b <b>55 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2542 Old Frederick Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28,</b>	
f. STREET ADDRESS <b>2542 Old Frederick Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>WILLIAM</b> Last <b>DYSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2,</b> Year <b>1957.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1901.</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline Pump Installer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence Dyson</b>		14. MOTHER'S MAIDEN NAME <b>Annie Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-07-2059</b>	
17. INFORMANT <b>Mrs. Annie M. Teal</b>		Address <b>2542 Old Frederick Road Catonsville 28, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 20</b> , 19 <b>57</b> , to <b>Feb 2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 2</b> , 19 <b>57</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Dr. L. A. Kochman</b> M.D. <b>Ellicott City, Md.</b> PHYSICIAN'S NAME (Type) <b>Dr. L. A. Kochman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 5, 1957.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>EB 5 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. L. Beach</b>

BUREAU A. S.

FEB 1977

RECEIVED



1482

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <b>6 Years</b>				X <b>Balto. Co. Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3519 Joppa Rd.</b>				d. STREET ADDRESS <b>3519 Joppa Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>W.</b> Last <b>Ellinger</b>				4. DATE OF DEATH Month <b>2</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1867</b> <b>Nov. 22, 1867</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Hillbinger 3519 Joppa Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1948</b> , to <b>Feb 8, 1957</b> , that I last saw the deceased alive on <b>Feb 8, 1957</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6217 Harford Rd Baltimore 14, Md.</b> DATE SIGNED <b>2/8/57</b>							
ACTUAL SIGNATURE <b>E. J. Alessi</b>		M.D. <b>6217 Harford Rd Baltimore 14, Md. 2/8/57</b>					
PHYSICIAN'S NAME (Type)		E. J. Alessi, M. D. 6217 Harford Road Baltimore 14, Md. 2/8/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Tunnell Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Malcolm Gray</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNAN V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01480

1483

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>5229 42nd Street</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Fairfield Eskite</b>				4. DATE OF DEATH Month Day Year <b>February 14, 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/22</b>	9. AGE (In years last birthday) <b>34 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Eskite</b>				14. MOTHER'S MAIDEN NAME <b>Helen Fairfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Rosewood Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe swelling of brain</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>glioma (astrocytoma) in right temporal lobe.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 13, 19 57</b> , to <b>February 14, 19 57</b> , that I last saw the deceased alive on <b>February 14, 19 57</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Rich. E. [Signature]</b> M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Feb 16, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas [Signature]</b>				ADDRESS <b>144 [Signature]</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 18 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary [Signature]</b>			

U. S. A.

RECEIVED

1484

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>20 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3401 N. Calvert Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>P.</b> Last <b>EVERSFIELD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1957</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1887</b>		9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contract Electrical work</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Edward W. Eversfield</b>		14. MOTHER'S MAIDEN NAME <b>Emily K. Pracht</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-09-5075</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LEFT LUNG WITH METASTASES</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 15, 1957</b> , to <b>February 4, 1957</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>2/4/57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland</b>																	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm./I. Tickner &amp; Sons, Inc., Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>2-5-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson K. Farley</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

8

RECEIVED

1485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>214 Bloomsbury Ave.</b>		d. STREET ADDRESS <b>214 Bloomsbury Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Feast</b> Last <b>Feast</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1864</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>	9. AGE (In years last birthday) <b>93</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME <b>John E. Feast</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Neily</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Miss Flora Feast</b>		Address <b>214 Bloomsbury Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Insufficiency</b> DUE TO (c) <b>Ch. Hypertensive Cardio. Vascular Renal Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 w. 2 d.</b> <b>15 y. 7.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3-2-1944</b> to <b>2-23-1957</b> , that I last saw the deceased alive on <b>2-22-1957</b> , and that death occurred at <b>3:40</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Bv.</b> DATE SIGNED ACTUAL SIGNATURE <b>Wm. K. Gallagher</b> M.D. PHYSICIAN'S NAME (Type) <b>Wm. K. Gallagher</b> <b>Catonsville-28, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. ...</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 1 '57</b>	24b. REGISTRAR'S SIGNATURE <b>...</b>

RECEIVED

MAR 1 1957

BUREAU V. S.



1486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>26 days</b>		d. STREET ADDRESS <b>4429 Clifton Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRED W. FITZPATRICK</b>		4. DATE OF DEATH Month Day Year <b>February 10 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/91</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Maker</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool &amp; Die Co</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Fitzpatrick</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Woodhead</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>216-28-7081</b>	17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE &amp; LEFT UPPER LOBE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>190X</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS OF THE LIVER</b> <b>ARTERIOSCLEROSIS CORONARY ARTERIES, ADVANCED</b> <b>ANEURYSM OF THE ABDOMINAL AORTA. EMBOLI LOWER POLE SPLEEN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 15, 1957</b> , to <b>February 10, 1957</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rolando P. Ponce de Leon</b> M.D.		ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b> DATE SIGNED <b>2/10/57</b>	
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE DE LEON, MD.</b>		<b>VAH, Fort Howard, Md.</b> <b>2-10-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-13-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cock-Blight Inc. Funeral Home</b> <b>6009 Harford Rd., Baltimore 14, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 13 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Dawson L. Larkins</b>	

BUREAU V. S.

FEB 1907

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7124 Eastbrook Avenue</u>		d. STREET ADDRESS <u>7124 Eastbrook Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Sarah A. Flaherty</u>		4. DATE OF DEATH <u>February 18th 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George T. Flaherty</u>		14. MOTHER'S MAIDEN NAME <u>Ellen O'Conor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Isenrock, 7124 Eastbrook Ave</u>		Mrs. <u>Mary Link</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic arterial hypertension</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years?</u> <u>years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 7</u> , 19 <u>57</u> , to <u>Feb 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>57</u> , and that death occurred at <u>9:30 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George D. Lippy</u>		ADDRESS (Street, city or town, state) <u>1668 Patterson St. Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>George D. Lippy</u>		DATE SIGNED <u>Feb 21 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/21/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>B</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Stanley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. P.

FEB 27 1951

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01485

Reg. Dist. No.

43

1488

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. STREET ADDRESS <u>5809 Farmview Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5809 Farmview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> First Middle		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15-1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng Bldg RR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg-RR</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Francis</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-3631</u>	
17. INFORMANT <u>Mrs Anna Francis</u>		Address <u>5809 Farmview Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON Monoxide Poisoning -</u> DUE TO <u>Auto Exhaust Fumes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto Exhaust Fumes</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FOUND DEAD IN CAR - MOTOR RUNNING</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-3-57</u> Hour <u>5</u> a.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>STREET</u>		20f. (City or town) <u>Baltimore Co.</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Russell S Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) <u>Baltimore Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel Funeral Home</u>		24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>	
ADDRESS <u>7401 Blaine Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. L. Reifsnieder</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. T. GENERAL DIRECTOR; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BUREAU V. A.

1913 4 10

RECEIVED

1489

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN TB 8 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb Nursing Home, Pikesville				d. STREET ADDRESS Buckingham Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA		First Middle Last FRIEDEL		4. DATE OF DEATH FEB, 11 19 57		Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 23, 1877	
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Hiedleberg, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl Witaope				14. MOTHER'S MAIDEN NAME Josephine Hammerick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Karl George Friedel, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 142X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1922 to 2/11/1927 that I last saw the deceased alive on 2/11/1927, and that death occurred at 5:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wm. E. Martin M.D. Randalstown Md 2/12/57 PHYSICIAN'S NAME (Type) Wm. E. Martin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/57		22c. NAME OF CEMETERY OR CREMATORY Oakland		22d. LOCATION (City, town, or county) (State) Sykesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Jewell, Pikesville, Md.				24a. REC'D BY REGISTRAR DATE 2/15/57		24b. REGISTRAR'S SIGNATURE Dorothy Jewell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5 2 00



## MARYLAND STATE DEPARTMENT OF HEALTH

01487

2411 N. Charles Street, Baltimore

## 1490 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u> <u>Eusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>710 Wicklow Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GEORGE J. FRITTS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 28, 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 12, 1881</u>
9. AGE last birthday <u>75 yrs.</u>		10. AGE last birthday If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Fritts</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>Mrs. Edith K. Fritts - 710 Wicklow Rd.</u>	

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Central Hemorrhage</u>		<u>13 days</u>
Antecedent cause(s) (b) <u>arteriosclerosis</u>		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Hypostatic pneumonia</u>	<u>36 hours</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from FEB 18, 1957, to FEB 28, 1957, that I last saw the deceased alive on FEB 27, 1957, and that death occurred at 1:50 A. m., from the causes and on the date stated above.

SIGNATURE <u>Paul R. Ziegler</u>	DATE <u>3/4/57</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>	LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>
DATE REC'D BY LOCAL REG. <u>APR 1 1957</u>	REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons - Balto 17</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

1491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>30 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PILE CREST NURSING HOME</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X FORT HOWARD</b> d. STREET ADDRESS <b>1 FORT HOWARD ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHRYN* CATHERINE EDITH FROCK</b>				4. DATE OF DEATH Month Day Year <b>FEB. 2, 1957</b> 19			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 24, 1893</b>	
9. AGE (In years last birthday) yrs. <b>63</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JOHN GERLACH</b>			
14. MOTHER'S MAIDEN NAME <b>CAROLINE RICHARDS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>		17. <del>DECEASED</del> <b>MR. EMORY M. FROCK</b>		Address <b>SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Collapse</b> <b>445X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Atherosclerosis with Hypertension</b> DUE TO (c) <b>1 yr</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/1</b> , 19 <b>57</b> , to <b>2/2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/2</b> , 19 <b>57</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3376 Linden Ave Baltimore</b> DATE SIGNED <b>Feb 29 1957</b> ACTUAL SIGNATURE <b>Danuta Plogia</b> M.D. INTERPRETER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b> <b>BALTIMORE MARYLAND.</b>				ADDRESS <b>Henry F. Sander</b>		24a. RECEIVED BY REGISTRAR <b>FEB 6 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>							

BUREAU V 8

FEB 9 1957

RECEIVED

1492

## CERTIFICATE OF DEATH

01489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				d. STREET ADDRESS <u>6 Waldron Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE SEISS GERNAND</u>				4. DATE OF DEATH Month Day Year <u>Feb. 25 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Edwin K. GERNAND</u>				14. MOTHER'S MAIDEN NAME <u>Frances MENCIEHA PARKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-03-3231</u>			
17. INFORMANT <u>Records, Spring Grove State Hosp.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Feb. 21</u> , 19 <u>57</u> , to <u>Feb. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 25</u> , 19 <u>57</u> , and that death occurred at <u>12:18</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove State Hosp. 2-25-57</u>							
ACTUAL SIGNATURE <u>Jerome E. Shapiro</u> M.D.				PHYSICIAN'S NAME (Type) <u>Jerome E. Shapiro, M.D. Catonsville 28 Md.</u>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 27/1957</u>		<u>Westminster and Co. Westminster, Md.</u>		<u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Haver</u>				ADDRESS <u>Pikesville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>Feb 27 57</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Haver</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

1493

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>509 E Joppa Rd</u>		e. STREET ADDRESS <u>1529 E Joppa Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ELMER CARL GERSTMAYER</u>		4. DATE OF DEATH <u>Feb 7</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18 1888</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>
13. FATHER'S NAME <u>Henry Gerstmyer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gelhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Elmer C Gerstmyer Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid with generalized metastasis</u> <u>153 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 20</u> , 19 <u>56</u> , to <u>Feb. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 5</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lloyd E. Saylor</u> M.D.		ADDRESS (Street, city or town, state) <u>3902 Greenmount Avenue</u> DATE SIGNED <u>2/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor, M. D.</u>		<u>Baltimore 18, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 11 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W Jenkins</u> ADDRESS <u>Amoco 4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>FEB 13 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

BUREAU V. S.

FEB 1 1917

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b> d. STREET ADDRESS <b>2517 McComas Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Gibson</b> Last <b>Gibson</b>				4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 11 1911</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork Co</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>William Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gillespie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Dorothy Gibson 2517 McComas Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4 x 3.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Heart</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>reburial</b>		<b>Feb 3/57</b>		<b>Abington Hill</b>		<b>Seranton Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave</b>				24a. REC'D BY REGISTRAR <b>Feb 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 7 1957

RECEIVED

1495

CERTIFICATE OF DEATH

01492

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>22yrs4mth27dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle Last <b>Gorera</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1882</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 10</b> , 19 <b>57</b> , to <b>Feb. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 11</b> , 19 <b>57</b> , and that death occurred at <b>2:00 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-11-57</b>			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>2-14-57</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>St. Mary's Cemetery</b>		<b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. M. Anatomical Board</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 2/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Victor C. Harry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S.

NEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01493

1496

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>4013 PARKWOOD AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>MARK</b> Middle <b>Charles</b> Last <b>GRABER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-94</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FOOD PROCESSING CO.</b>		11. BIRTHPLACE (State or foreign country) <b>CATONSVILLE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ADAM B. GRABER</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE C. HEMLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>212-40717533</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>134.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LEFT HEART INSUFFICIENCY</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b>  <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>February 22, 1957</b> , to <b>February 22, 1957</b> , and that death occurred on <b>February 22, 1957</b> , at <b>4:25 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Roland D. Ponce de Leon</b> M.D.				ADDRESS (Street, city or town, state) <b>VAF, FORT HOWARD, MD.</b>			
PHYSICIAN'S NAME (Type) <b>ROLAND D. PONCE de LEON, M. D.</b>				DATE SIGNED <b>2/23/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEONARD J. WICK, INC.</b>				ADDRESS <b>5305 Harford Road, Baltimore, MD.</b>		24a. REC'D BY REGISTRAR <b>26-1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Russell L. Fisher</b>			

BUREAU V. S.

FEB 26 1957

RECEIVED

1436

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Arbutus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1124 Meadow Lark Drive</b>		d. STREET ADDRESS <b>1124 Meadow Lark Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Grain</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1868</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Appel</b>		14. MOTHER'S MAIDEN NAME <b>Margaret-----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (DAUGHTER) <b>Mrs. Joseph Frye, 1124 Meadow Lark Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive C.V. Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Branch pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1948</b> to <b>Feb. 20, 1952</b> that I last saw the deceased alive on <b>Feb. 20, 1952</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Milton Sisco</b>		ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Milton Sisco</b>		DATE SIGNED <b>2/21/52</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b>		24a. REC'D BY REGISTRAR <b>2-21-57</b>	
ADDRESS <b>4101 Edmondson Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. Kipper</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 25 1957  
BUREAU Y. S.



1497

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>13 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>20 Southgate Avenue</b>		
3. NAME OF DECEASED (Type or print) First <b>Wesley</b> Middle <b>Gregory</b> Last <b>Gregory</b>			4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1868</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>furniture merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>472.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Feb. 3</b> , 19 <b>57</b> , to <b>Feb. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 3</b> , 19 <b>57</b> , and that death occurred at <b>2:15 p. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Gertrude J. Fleischmann</i>		PHYSICIAN'S NAME (Type) <b>GERTRUDE J. FLEISCHMANN</b>		DATE SIGNED <b>23 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln</b>	
22d. LOCATION (City, town, or county) <b>Prince Georges</b>		22e. (State) <b>MD.</b>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Byerly</i>		ADDRESS <b>Chesapeake</b>		24a. REC'D BY REGISTRAR DATE <b>2/5/57</b>	
24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

73 7 1957

BUREAU V. 8

1498

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>				c. LENGTH OF STAY IN 1b <b>10 min. approx.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Central Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Eliza</b> Last <b>Grimes</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 26, 1885</b>	
9. AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William Rawlings</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>A. Olin Grimes, Finksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angina Pectoris</b> <b>420.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic C.-V. Disease 13 yrs.</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>May 8</b> , 1955, to <b>Feb. 28</b> , 1957, that I last saw the deceased alive on <b>Feb. 25</b> , 1957, and that death occurred at <b>12:15 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Road</b> DATE SIGNED <b>3-1-57</b>							
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.				PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Skene</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>				ADDRESS			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNELL & S.

RECEIVED

1499

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperside (Rural)</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA--M--HALE</u>				4. DATE OF DEATH <u>Feb 5</u> 19 <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28-1865</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Wolfgang</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Clarence Hale - Upperside Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>54</u> , to <u>February 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 5</u> , 19 <u>57</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>2/5/57</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				LOCATION (City, town, or county) <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Carmel</u>		22d. LOCATION (City, town, or county) <u>Balto MD</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Dighton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DATE 2-8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 11 1917

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Notch Cliff Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Notch Cliff near Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		d. STREET ADDRESS <b>Glenarm Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister Mary Floriberta Hallameyer</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4th</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1867</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	9. AGE (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank HALLAMEYER</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Knolmeyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Sister M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio- Renal Vascular Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August</b> , 19 <b>52</b> , to <b>February</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>January 30th</b> , 19 <b>57</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road, Towson 4, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-6-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Jailer</b>		24a. REC'D BY REGISTRAR <b>401 S. CONKLING ST. BALTO. 24 MD.</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>

BUREAU A. F.

FEB 7 1957

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

1591

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr8mth12dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>M.</b> Last <b>Hare</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8,</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1873</b>
9. AGE (In years last birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>57</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mr. Elia Walker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Walker Bortner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic nephrosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4</b> days <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 6</b> , 19 <b>57</b> , to <b>Feb. 8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 8</b> , 19 <b>57</b> , and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachler</b>		DATE SIGNED <b>2-8-57</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Febr. 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls E. B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Millers, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Hartenstein</b>		24a. REC'D BY REGISTRAR <b>Feb 13 '57</b>	
ADDRESS <b>New Freedom, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page \_\_\_\_\_ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages \_\_\_\_\_ and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FAU V. S.

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Essex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>313 George Avenue</b>		d. STREET ADDRESS <b>313 George Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>S.</b> Last <b>Harrison</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1862</b>
9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>2</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Florence Stone</b>		Address <b>313 George Avenue, Essex</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>445x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>7 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. p. <b></b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I attended the deceased from <b>April 19 51</b> to <b>February 19 57</b> that I last saw the deceased alive on <b>February 23 19 57</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL DECEASED TIME <b>Joseph Miceli</b> M.D. <b>108 S. Taylor Ave.</b>		DATE SIGNED <b>2/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Miceli, M.D.</b>		<b>Baltimore 21, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR <b>2-25-57</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 22 1957  
BUREAU V. S.

1503  
CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr6mth23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M.</b> Last <b>Heintzmann</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1867 Nov. 27</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>9</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pleasant Grove, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry King</b>		14. MOTHER'S MAIDEN NAME <b>Anna Kerchner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vase. Failure</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic</b> DUE TO (c) <b>Arteriosclerotic</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 29, 1957</b> , to <b>2/9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/9</b> , 19 <b>57</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2/9/57</b> ACTUAL SIGNATURE <b>S. Wachslar</b> M.D. PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> Catonsville 28k Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Arcadia, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline + Sons</b>		24a. REC'D BY REGISTRAR <b>2-9-57</b>	
ADDRESS <b>Tricasterstown</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALBERT V. B.

1934

## 1594 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hood Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ELEANOR</b> Last <b>HEPDING</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 25, 1863</b>
9. AGE (In years last birthday) <b>93 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>2</b> Min.	11. IF UNDER 24 HRS. Months <b>10</b> Days <b>10</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cornthwaite</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Giffin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ernest O. Hepding</b>		Address <b>201 S. Symington Ave. Catonsville 28, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arterio Sclerosis</b> DUE TO <b>Sanguine of feet</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. p.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-4-56</b> to <b>2-20-57</b> , that I last saw the deceased alive on <b>2-19-57</b> , and that death occurred at <b>3:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James Estwood</b>		ADDRESS (Street, city or town, state) <b>Catonsville</b>	
PHYSICIAN'S NAME (Type) <b>James Estwood</b>		DATE SIGNED <b>2-21</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		ADDRESS <b>Catonsville 28 Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 25 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PAU V. S.

FEB 25 1953

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01503

1595

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3058 Oak Forrest Drive</u>				d. STREET ADDRESS <u>1 3058 Oak Forrest Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. Louis Theodore Heying, Jr.</u>				4. DATE OF DEATH <u>February 22 19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30, 1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter Edgewood Ars.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Heying</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Franze</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>220-20-7099</u>		17. INFORMANT <u>Mrs. Alice Heying, 3058 Oak Forrest Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary artery disease</u> DUE TO <u>8 yrs.</u> (c) <u>Hyper-tension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyper-tension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 Apr 1</u> , 19 <u>49</u> to <u>Feb 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 8</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Osburne</u> M.D.		ADDRESS (Street, city or town, state) <u>5600 Hampden Rd. Brooklyn, Md.</u>		DATE SIGNED <u>Feb 22 1957</u>			
PHYSICIAN'S NAME (Type) <u>John C. Osburne M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn A.A. Co Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #04</u>				24a. REC'D BY REGISTRAR <u>FEB 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Burns</u>	

RECEIVED

SEP 11 1957

UNITED STATES

1506

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3V 14 Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Spring Grove Hosp. Catonsville Md.</b>		d. STREET ADDRESS <b>739 Wash. Bl</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM HEYMAN</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>10</b> - Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-95</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUTTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUBAN HEYMAN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA LIPSHTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LENA MILLER</b>		Address <b>BALTO 4103 MAINE AVE.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastasis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **JAN. 19, 1957**, to **FEB. 10, 1957**, that I last saw the deceased alive on **FEB 10, 1957**, and that death occurred at **10:30 A.M.**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Spring Grove Hosp. Balto.** DATE SIGNED **2-10-57**  
ACTUAL SIGNATURE **David E. Edwards** M.D.  
PHYSICIAN'S NAME (Type) **David E. Edwards, M. D.** **SPRING GROVE STATE HOSPITAL**

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>2-12-57</b>	<b>Unai Israel</b>	<b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Mc</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '57</b>	
ADDRESS <b>2100 Eutaw Place</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01505  
37

## CERTIFICATE OF DEATH

Reg. Dist. No.

1597

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>102 OAK DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <del>EDWIN T. HOBBS</del> <b>EDWIN T. HOBBS</b>				4. DATE OF DEATH Month Day Year <b>2 4 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-31-1880</b>	9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPPLY SUPERINTENDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ret. C&amp;P Tel. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWIN T. HOBBS</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA HULLER WRIG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-0598B</b>		17. INFORMANT <b>T. HOBBS, SR. wife</b> Address <b>Hospital records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aneurysm of aorta</b> DUE TO (c) <b>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-23-</b> , 19 <b>56</b> , to <b>2-3-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-3-</b> , 19 <b>57</b> , and that death occurred at <b>12:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William Newcomer M.D.</b> <b>2-4-57</b>							
ACTUAL SIGNATURE <b>William Newcomer</b>				PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> <b>Mt. Wilson, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke,</b>				ADDRESS <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 6 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Stanley D. Wells</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01506

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>802 North Woodlynn Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM M. HOFFMAN</b>				4. DATE OF DEATH Month Day Year <b>February 27 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Navigator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Marines</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Catherine MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes SAW</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> <b>150x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION AND ARTERIOSCLEROSIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>  <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>February 19 1957</b> , to <b>February 27, 19 57</b> , and that death occurred at <b>1:28 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 2/27/57</b>							
ACTUAL SIGNATURE <b>W. L. Dudley</b>				M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. G. Connelly and Sons, Baltimore 21, Md.</b>				24a. REC'D BY REGISTRAR <b>AR 1 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Fisher</b>	
ADDRESS <b>418 Eastern Avenue</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 1 1957  
BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01507

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1509

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>John Horner Baltimore</u> <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>3 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Nursing Home, Edmondson Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3800 Clifton Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Horner</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>24</u> Year <u>19 57</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>DATE OF BIRTH</b> <u>Aug. 18, 1877</u> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Navy</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto. Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Joshua Horner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Mary Mitchell</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Dorothy Howard</u> Address <u>211 Stoney Run lane</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute Cardiac failure,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerotic heart disease</u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
<b>ACTUAL SIGNATURE</b> <u>Geo. S. M. Kieffer</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Feb. 24, 1957</u>				
<b>EXAMINER'S NAME (Type)</b> <u>Geo. S. M. Kieffer</u>		<b>M. D.</b>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				
<b>22b. DATE THEREOF</b> <u>Feb 26, 57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Mount</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore Md.</u>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John O. Mitchell &amp; Sons</u>				<b>ADDRESS</b> <u>1900 Euraw Place, Balto</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Feb 27 1957</u>		
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Alfred</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director prior to burial, cremation, or removal. File pages 1 and 2 with the

BUREAU N. E.

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CERTIFICATE OF DEATH

01508

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Manatee</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>44 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradenton 48X</b>		d. STREET ADDRESS <b>814 - 6th Avenue, West</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>S.</b> Last <b>HUDON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1923</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repair &amp; Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Radio &amp; Television</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel H. Hudon</b>		14. MOTHER'S MAIDEN NAME <b>Irma Delbousiere</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>030-18-0981</b>	
17. INFORMANT <b>Clin. Rec., Vet. Administration Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUPRASELLAR MENINGIOMA</b> <b>2d3X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>POST CRANIOTOMY ABSCESS OF BASE OF THE BRAIN</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 YRS</b> <b>2 MOS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cystitis &amp; bilateral pyelonephritis. Thrombosis left and right lower lobes</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1956</b> , to <b>Feb. 1</b> , 19 <b>57</b> and that death occurred on <b>Feb. 1</b> , 19 <b>57</b> at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rolando D Ponce de Leon</b> M.D.		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>ROLANDO D PONCE DE LEON</b>		DATE SIGNED <b>2/2/57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-3-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manasota Burial Plot</b>		22d. LOCATION (City, town, or county) (State) <b>Oneco, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM COOK - BLIGHT</b>		24. REG'D BY REGISTRAR <b>FEB 4 1957</b>	
ADDRESS <b>6009 Harford Rd. Balto</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

1511

## Reg. Dist. No.

38

## MEDICAL CERTIFICATION

RECEIVED

FEB 20 1957

BUREAU V. A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.  
FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01549

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution; Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN <b>Baltimore 3401-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Co. Hospital</b>				d. STREET ADDRESS <b>168 West St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Junius</b> Middle <b>A.</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-14-1916</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Jones</b>				14. MOTHER'S MAIDEN NAME <b>Adelide ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Elise Jones 935 Sharp Street</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of vomitus due to syphilitic</b> <b>X DUE TO</b> <b>coronary ostial stenosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
MEDICAL CERTIFICATION							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
<b>Burial</b>				<b>3-3-57</b>			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
<b>Mt. Auburn Ct.</b>				<b>Baltimore, City.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah Brown &amp; Son</b>				24a. RECORD BY REGISTRAR DATE <b>2/28/57</b>			
ADDRESS <b>108 W</b>				24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farkley</b>			

RECEIVED  
JUN 1 1957  
BUREAU V. S.



1513

## CERTIFICATE OF DEATH

01511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>KAISER</u> Last <u>KAISER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown by dec.</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown by deceased</u>	
11. BIRTHPLACE (State or foreign country) <u>unknown by dec. on adm.</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown by dec.</u>	
13. FATHER'S NAME <u>unknown by dec. on admission (single)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown by dec. on admission</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Joseph Y. Loveman</u>		Address <u>Harlem Lane Catonsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation left leg by Arteriosclerosis gangrene</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/22, 1956</u> , to <u>2/4, 1957</u> , that I last saw the deceased alive on <u>2/4, 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u>		DATE SIGNED <u>2/5/57</u>	
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u>		M.D. <u>4605 Edmondson Ave</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 EDMONDSON AVE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/6/57</u>	<u>St Paul Cemetery</u>	<u>O'Donnell St Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Martin</u>		24a. REC'D BY REGISTRAR <u>Feb 8 '57</u>	
ADDRESS <u>1902 Eubank place</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

FEB

RECEIVED

1514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8903 Liberty Rd.</b>		d. STREET ADDRESS <b>8903 Liberty Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>DONALD</b> Last <b>KERSHNER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>9,</b> Year <b>19 57</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1907</b>
9. AGE (In years last birthday) <b>49</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personnel Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Alexander Kershner</b>		14. MOTHER'S MAIDEN NAME <b>Della Eva Shumaker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Frances L. Kershner - 8903 Liberty Rd.</b>		Address <b>Randallstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4-2-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive and arteriosclerotic</b> DUE TO <b>cardiovascular disease</b> (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden death</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 March, 1949, to 9 Feb</b> , 1957, that I last saw the deceased alive on <b>8 Feb</b> , 1957, and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>803 Medical Arts Bldg Baltimore</b> DATE SIGNED <b>11 Feb 57</b>			
ACTUAL SIGNATURE <b>Ernest S. Cross Jr</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Ernest S. Cross, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17th</b>		24a. REC'D BY REGISTRAR DATE <b>2-13-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. E. Martin</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

321

200

ONE

1515

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Y</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>20yrlmthlldys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> <u>King</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George King</u>				14. MOTHER'S MAIDEN NAME <u>Anna Wagengast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOS IT-L</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Infarctive myocardial fibrosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 4</u> , 19 <u>57</u> , to <u>Feb. 19</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>Feb. 19</u> , 19 <u>57</u> , and that death occurred at <u>7:30a.m.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>2-19-57</u>							
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D.				PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>22/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>	
22d. LOCATION (City, town, or county) <u>BALTO., MD.</u>				22e. (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grace P. Hoffmann</u>				ADDRESS <u>2334 Jefferson St.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 21 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 27 19  
BUREAU V. S.

## CERTIFICATE OF DEATH

1516

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>1</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>		LENGTH OF STAY (in this place) <b>6 Mos.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6729 Windsor Mill Rd.</b>				STREET ADDRESS (If rural give location) <b>6729 Windsor Mill Rd.</b>			
3. NAME OF DECEASED (Type or Print) <b>WALTER C. KIRK</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 15 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>June 20, 1887</b>	9. AGE last birthday <b>69</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hebbville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Kirk</b>				14. MOTHER'S MAIDEN NAME <b>Anna Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-0276</b>		17. INFORMANT & ADDRESS <b>Mrs. Eleanor Mohler</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)				6729 Windsor Mill Rd. <b>metastatic carcinoma</b> ONSET AND DEATH <b>7-8 mos</b>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7/15</b> , 19 <b>57</b> , to <b>7/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/11</b> , 19 <b>57</b> , and that death occurred at <b>12 noon</b> , from the causes and on the date stated above.							
SIGNATURE <b>Milton Schlenker</b>				DATE SIGNED <b>Feb. 13, 1957</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 18, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>FE BELL SWORTH ARMACOST</b>		REGISTRAR'S SIGNATURE <b>Dr. J. M. C. Martin</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Greenworth Armacost</b>		ADDRESS <b>4600 LIBERTY HEIGHTS AVENUE</b>	

**INSTRUCTIONS**

**1** **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The uniform copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. A.

1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

UNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01515

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Parsonage Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Nzomi</i> Middle <i>O.</i> Last <i>Kiser</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>18</i> Year <i>1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar. 26 1908</i>	
9. AGE (in years last birthday) <i>48</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Canning Fact.</i>	
11. BIRTHPLACE (State or foreign country) <i>Parkton, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Nelson Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Rose Warner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Claude Kiser, Parkton, Md.</i>	
17. INFORMANT <i>Claude Kiser, Parkton, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>831X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>A. M. France</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>A. M. FRANCE</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>2/20/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-27-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove E. B. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Parkton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hartenstein, New Freedom, Pa.</i>		24a. REC'D BY REGISTRAR <i>2/20/57</i>	
ADDRESS <i>New Freedom, Pa.</i>		24b. REGISTRAR'S SIGNATURE <i>Charles J. Fuller</i>	

RECEIVED  
FEB 25 1957  
BUREAU V. S.

1518

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 3401-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>2504 BROOKFIELD AVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>KOCH</b> Last		4. DATE OF DEATH Month <b>FEB</b> Day <b>20</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>PENN.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>BENJAMIN SALLER</b>		14. MOTHER'S MAIDEN NAME <b>REGINA NEUMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-01-1281</b>	
17. INFORMANT <b>Frank L. Smith, Cockeysville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-20, 1954, to 2-20, 1957</b> , that I last saw the deceased alive on <b>12-20, 1957</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walter T. Kees, Cockeysville, Md.</b> DATE SIGNED <b>2/20/57</b>			
ACTUAL SIGNATURE <b>WALTER T. KEES</b>		M.D. <b>Cockeysville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>
22d. LOCATION (City, town, or county) (State) <b>BALTO Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc 1217 St Paul St</b>		24a. REC'D BY REGISTRAR DATE <b>2-21-57</b>	24b. REGISTRAR'S SIGNATURE <b>Frank Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 24 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Form 12-25-51 et

1519

## CERTIFICATE OF DEATH

Reg. Dist. No.

01517  
40

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9335 Belair Rd.</b>		d. STREET ADDRESS <b>9335 Belair Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Kost</b> Last <b>Kost</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>14</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1902</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR: Months <b>14</b> Days <b>19</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glen L. Martin</b>	
11. BIRTHPLACE (State or foreign country) <b>Lorain Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michal Kost</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hudak</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-03-5435</b>	
17. INFORMANT <b>Mrs. Billie Kost</b>		Address <b>9335 Belair Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Feb</b> , 1957, to <b>14 Feb</b> , 1957, that I last saw the deceased alive on <b>8 Feb 57</b> , 1957, and that death occurred at <b>11A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>2-14-57</b>			
ACTUAL SIGNATURE <b>George D. Edwards</b> M.D. <b>9660 Belair Rd. Baltimore, Md.</b>		PHYSICIAN'S NAME (Type) <b>GEORGE D. EDWARDS, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fullerton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sarah Home</b>		ADDRESS <b>7401 Belair Rd. 6</b>	
24a. REC'D BY REGISTRAR <b>FEB 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter J. Hannon</b>	

REAU V. S.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1520

## CERTIFICATE OF DEATH

01518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 3V 11-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>6613 REISTERTOWN RD</b>	
3. NAME OF DECEASED (Type or print) <b>EMILY</b> First <b>MAE</b> Middle <b>KREEGER</b> Last		4. DATE OF DEATH <b>FEB 18 1957</b> Month <b>18</b> Day <b>1957</b> Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 3, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM H. H. CULLIMORE</b>		14. MOTHER'S MAIDEN NAME <b>EMILY WARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Thos. J. Cullimore, Jr.</b> Address <b>52-104 4th Ave. - Glen Burnie</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerosis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cardio-vascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/31/56</b> , 19____, to <b>2/15/57</b> , 19____, that I last saw the deceased alive on <b>2/15/57</b> , 19____, and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter T. Kees</b>		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>2/18/57</b>	
PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/20/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons - North &amp; Pa. Aves</b>		24a. REC'D BY REGISTRAR <b>DATE 2-19-57</b>	24b. REGISTRAR'S SIGNATURE <b>Frank Smith</b>

BUREAU V. S.

FEB 20 1957

RECEIVED  
37



## CERTIFICATE OF DEATH

1431

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO.		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN DUNDALK		37 YRS		TOWN DUNDALK			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1726 LESLIE AVE.				STREET ADDRESS (If rural give location) 1726 LESLIE AVE.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) THOMAS JERE LAU				4. DATE OF DEATH (Month) (Day) (Year) 2-21-57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED	8. DATE OF BIRTH JUNE 6, 1896	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN D. LAU				14. MOTHER'S MAIDEN NAME HATTIE MOORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. 77-07-335		17. INFORMANT & ADDRESS CATHERINE S. LAU - SAME			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) CARCINOMA of LEFT LUNG						6 MOS -	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 1956, to Feb. 21, 1957, that I last saw the deceased alive on Feb. 21, 1957, and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
M.D. Brown		M.D. 6800 Mornington Row - Dundalk 22 2/23/57					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/25/57		NAME OF CEMETERY OR CREMATORY CATH LATHAN		LOCATION (City, town, or county) (State) BALTO CO MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE FEB 25 1957		Hon. Kelly		White River Road, Dundalk, 190			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be filed with the registrar in 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar in 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED  
FEB 25 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01520

1521

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT. HOWARD</b> c. LENGTH OF STAY IN 1b <b>38 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>AVENUE A—TODDS FARM</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOX 163 ROUTE 10—BALTO 19</b> d. STREET ADDRESS <b>TODDS FARM</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HILJA</b> Middle <b>MARIE</b> Last <b>LEINO</b>		4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19, 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b> IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FINLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>FINLAND</b>	
13. FATHER'S NAME <b>ALEXANDER LEINO</b>		14. MOTHER'S MAIDEN NAME <b>BEETA. (UNK.)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>22044-333</b>	
17. INFORMANT <b>MRS. A. F. KANIMANN—</b>		Address <b>3 SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> + add. DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>8 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 1, 1956</b> to <b>Feb. 25, 1957</b> , that I last saw the deceased alive on <b>Feb. 24, 1957</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David Owens</b> M.D.		ADDRESS (Street, city or town, state) <b>917 D St. Balto. 19 Md.</b>	
DATE SIGNED <b>2/25/57</b>			
PHYSICIAN'S NAME (Type) <b>David Owens</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-27-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Walt Whitely</b>	22d. LOCATION (City, town or county) (State) <b>Balto. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walt Whitely</b>		ADDRESS <b>Baltimore, Md.</b>	
4a. REC'D BY REGISTRAR <b>FEB 27 1957</b>		DATE	
REGISTRAR'S SIGNATURE <b>Dawson L. Selig</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

1522

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>184 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>LIST</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/81</b>		9. AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Lunch Room</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank List</b>				14. MOTHER'S MAIDEN NAME <b>Mary Anne Himmler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>224-12-5938</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT LOWER LOBE WITH METASTASIS TO</b> <b>LEFT MIDDLE AND UPPER RIGHT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONIA RIGHT LUNG</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 24, 1956</b> , to <b>February 24, 1957</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 2/24/57</b>							
ACTUAL SIGNATURE <b>Roland D. Ponce de Leon</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ROLAND D. PONCE de LEON, M. D.</b> Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM COOK-BLIGHT</b> ADDRESS <b>6009 Harford Rd Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Lasky</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

12

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

31

1523

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>				c. LENGTH OF STAY IN 1b <b>2 Weeks</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle Last <b>LIVESAY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1951</b>		9. AGE (In years last birthday) <b>5</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Christie Livesay</b>				14. MOTHER'S MAIDEN NAME <b>Jane Hilbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Cornie Johnson - Shadville, Tenn.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive incineration of body</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Conflagration of house</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Feb. 20 19 57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Marriottsville Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hamlet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shadville, Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Harry Allen</b> ADDRESS <b>Lynchville, Md.</b>				24a. REC'D BY REGISTRAR <b>2-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. Martin</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
MAR 1 1955  
BUREAU V. S.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01523

Reg. Dist. No.

31

1524

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>			c. LENGTH OF STAY IN lb <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle Last <b>LIVESAY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 57</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 4, 1933</b>		
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Hilbert</b>				14. MOTHER'S MAIDEN NAME <b>Cornie Williams</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Cornie Johnson, Shredville, Tenn.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive incineration of body</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration of house</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Feb. 20 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Marriottsville Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <b>2/20/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shredville, Tenn.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Harry Wren, Shredville, Md.</b>				24a. REC'D BY REGISTRAR <b>2-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Jm. Martin</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED  
MAR 1 1957  
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01524

Reg. Dist. No.

31

1525

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Marriottsville</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">2 Weeks</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Baltimore</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Marriottsville</span> d. STREET ADDRESS <div style="text-align: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></div>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <span style="font-size: 1.2em;">JANICE</span></span> <span>Middle</span> <span>Last <span style="font-size: 1.2em;">LIVESAY</span></span> </div>			<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <span style="font-size: 1.2em;">February</span></span> <span>Day <span style="font-size: 1.2em;">20</span></span> <span>Year <span style="font-size: 1.2em;">19 57</span></span> </div>				
<b>5. SEX</b> <span style="font-size: 1.2em;">F.</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">W</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <div style="display: flex; justify-content: space-around;"> <span>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></span> <span><span style="font-size: 1.2em;">Dec. 6, 1955</span></span> </div>			
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">1</span> Yrs.		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;">2</span> Days <span style="font-size: 1.2em;">14</span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;">1</span> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Tennessee</span>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>							
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles Livesay</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Jane Hilbert</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">None</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Bernie Johnson - Shredville, Tenn.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>          IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Massive incineration of body</span>  <div style="margin-top: 10px;">           7/16/57            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            DUE TO (b) _____            DUE TO (c) _____         </div> </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">Conflagration of house</span>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="display: flex; justify-content: space-around;"> <span>Hour <span style="font-size: 1.2em;">a. m.</span></span> <span><span style="font-size: 1.2em;">Feb. 20 1957</span></span> </div>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Home</span>			
<b>20f. (City or town)</b> <span style="font-size: 1.2em;">Marriottsville</span>		<b>(County)</b> <span style="font-size: 1.2em;">Maryland</span>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">William V. Lovitt, Jr.</span>			<b>DATE SIGNED</b> <span style="font-size: 1.2em;">2/20/57</span>				
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">William V. Lovitt, Jr., M.D.</span>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">2-23-57</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Family Cemetery</span>			
<b>22d. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">Shredville, Tenn.</span>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">C. Harry Warr - Shredville, Md.</span>			<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">2-23-57</span>				
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Dr. Hm. Masterson</span>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

BUREAU V. S.

1957 1 2

RECEIVED

1526

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rossville,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rossville,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Ridge Road</b>	
3. NAME OF DECEASED (Type or print) <b>Susan Newbold Mace</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Newbold Trump</b>		14. MOTHER'S MAIDEN NAME <b>Juliet Candy Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Otis Mace Phoenix, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction old</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 12, 1948</b> , to <b>Feb 4, 1957</b> , that I last saw the deceased alive on <b>Mar 2, 1956</b> , and that death occurred at <b>7:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 E. Read St.</b> DATE SIGNED <b>Feb 4, 1957</b>			
ACTUAL SIGNATURE <b>Edward F. Cotter</b> M.D.		DATE SIGNED <b>Feb 4, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edward F. Cotter</b>		ADDRESS <b>6 E. Read St.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>FEB 5 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. L. L. Ruffin</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUTLER & B.

FEB 5

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01526

1527

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley Rd.</b>		d. STREET ADDRESS <b>Valley Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth R.</b> Middle <b>Maddox</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William E. Maddox</b>		14. MOTHER'S MAIDEN NAME <b>Frances Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harry E. Maddox</b>		Address <b>Stevenson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 10th, 1953</b> , to <b>FEB. 12th, 1957</b> , that I last saw the deceased alive on <b>February 11th, 1957</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James A. Miller M.D.</b>		ADDRESS (Street, city or town, state) <b>Pikesville - 8, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James A. Miller</b>		DATE SIGNED <b>2/12/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanahan Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>DATE 2/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

STAC

101



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1437

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY <u>Brooklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Highlands</u> (" 1 Wk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3006 Georgia Ave (27)</u>				d. STREET ADDRESS <u>6429 2nd Ave 69X-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>Marzano</u> Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mch, 14, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>?</u>							
13. FATHER'S NAME <u>? Marzano</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Josephine Nykyforchyn. 1331 Cambra St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20.1</u> (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>	
				22d. LOCATION (City, town, or county) <u>Brooklyn, New York</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vanella Funeral Home-33 Madison St. New York</u>				24a. REC'D BY REGISTRAR <u>FEB 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. S. M. Kieffer</u>	
				N. Y.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 7 1957  
BUREAU V. S.



571

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1529

## CERTIFICATE OF DEATH

01529

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Notch Cliff near Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Notch Cliff near towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Villa Maria, Glenarm Rd.</b>				d. STREET ADDRESS <b>Glenarm Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Zita Maushardt</b>				4. DATE OF DEATH Month Day Year <b>Feb. 23 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1877</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Maushardt</b>				14. MOTHER'S MAIDEN NAME <b>Lena Keornaly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Sr. Mary Clara Notch Cliff, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6</b> , 19 <b>54</b> , to <b>Feb. 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 19</b> , 19 <b>57</b> , and that death occurred at <b>11.00</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D. ADDRESS (Street, city or town, state) <b>&amp; 7501 York Rd. Towson, Md.</b> DATE SIGNED PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NRTOWSON, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Giller</b>				24a. REC'D BY REGISTRAR <b>901 S. CONKLING ST. BALTO., 24, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Krueger</b>	

ST. A. H. V. S.



1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>18 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>A</b> Last <b>McBRIDE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-93</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFRIGERATION</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN J. McBRIDE</b>		14. MOTHER'S MAIDEN NAME <b>MARY GALLAGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>161 09 3732</b>	17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 23, 1957</b> , to <b>February 10, 1957</b> , and that death occurred at <b>7:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George C. Godfrey</i>		ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>George C. Godfrey</b>		DATE SIGNED <b>2-10-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-11-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>
22d. LOCATION (City, town, or county) (State) <b>PHILADELPHIA, PENNSYLVANIA</b>		24a. REC'D BY REGISTRAR <b>23 13 1957</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. COOK-BLIGHT INC. FUNERAL HOME</b> <b>6009 HARBOR ROAD, BALTIMORE 11, MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <i>James L. Fisher</i>	

BUREAU V. S.

FEB 13 1957

RECEIVED



1531

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 9 FilmG210 2-18-57 et

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Rural: TowsonLENGTH OF STAY (in this place) 2mo 8daHOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium  
Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY ✓

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore

STREET ADDRESS

(If rural give location)

10 E. Read St Balto Md

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

MONICA M.Mc CARTHY

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Feb 1019 57

## 5. SEX:

F

## 6. COLOR OR RACE:

W7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

## 8. DATE OF BIRTH:

May 13, 1891

## 9. AGE

birthday: 6/6 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.

RETIRED INSPECTOR

## 10b. KIND OF BUSINESS OR INDUSTRY:

STATE DEPT LABOR INDUSTRY

## 11. BIRTHPLACE (State &amp; foreign country):

Balto. md

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

John McCarthy

## 14. MOTHER'S MAIDEN NAME:

Ellen Coleman

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Personal History  
Hospital Records, Eudowood Sanatorium

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

15 days

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-22, 1956, to 2/10, 1957, that I last saw the deceasedalive on 2/9, 19 57, and that death occurred at 3:05 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

1/11Mabel Gray16 W. Meade and Son 200 N. Calvert St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

Body Released by Dr. Allen Hudson to be autopsied at Church  
Hend Hosp. by Dr V. Norwood

BUREAU V. S.

NOV 14 1957

RECEIVED

1532

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>193 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1430 Linden Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LAYTON</b> Middle <b>(NMI)</b> Last <b>MC DANIEL</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Centreville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Georgiana Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>212-10-3024</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC NEPHROSCLEROSIS BILATERAL</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EDEMA</b> DUE TO (c) <b>ANASARCA HYPOPROTEINEMIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>TERMINAL</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 30, 1956</b> , to <b>February 8, 1957</b> , that cause of death was <b>CHRONIC NEPHROSCLEROSIS BILATERAL</b> and that death occurred at <b>3:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>ROLANDO D. PONCE DE LEON, M.D. VAH, FORT HOWARD, MARYLAND 2/9/57</b> ACTUAL SIGNATURE <b>ROLANDO D. PONCE DE LEON, M.D. VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Funeral Home, 802-04 Madison Ave. Baltimore, 1, Md.</b>				24a. REC'D BY REGISTRAR <b>Feb. 12-57 Dawson L. Foster</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

U. S. A.

1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01533

1533

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>141 Wilgate Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE LESTER MCKEE</u>		4. DATE OF DEATH Month Day Year <u>February 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 16, 1898</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry McKee</u>		14. MOTHER'S MAIDEN NAME <u>Minnie A. Giveling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>299-01-0168</u>	
17. INFORMANT <u>Mrs. May McKee</u>		Address <u>141 Wilgate Road, Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>47°C</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 1955, to <u>Feb. 1</u> , 1957, that I last saw the deceased alive on <u>Feb. 1</u> , 1957, and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown, Maryland Feb. 2, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Feb. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-4-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	

BUREAU V. S.

FEB 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Parkton)</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (In an automobile)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5721 Highgate Drive</b>	
		d. STREET ADDRESS <b>5721 Highgate Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Louis Robert Willard</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 17 1914</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fish Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Willard</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>214-018483</b>	
17. INFORMANT <b>Louise Lee Willard</b>		Address <b>Highgate 5721 E. Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> <b>973.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>A. M. France</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>A. I. France</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>2/10/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Young Byers</b>		24a. REC'D BY REGISTRAR <b>2-13-57</b>	
ADDRESS <b>5005 W. Hyatt Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Chester L. France</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01535

1535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. LENGTH OF STAY IN 1b <b>28</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2729 Frederick Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE MILLER</b>				4. DATE OF DEATH Month Day Year <b>Feb. 4, 1957 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-20-1899</b>	9. AGE (In years last birthday) yrs <b>57</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Granite, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Boone</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>George B. Miller, Catonsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse Metastatic Carcinoma</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/17</b> , 19 <b>56</b> , to <b>2/4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/4</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor J. Zeng</b>		M.D. <b>715 Fushick Ave - Balt 28</b>		DATE SIGNED <b>2/5/57</b>		ADDRESS (Street, city or town, state)	
FICIAL NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR <b>7 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

RECEIVED

1957

RECEIVED

## 1536 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>813 J Street</u>		d. STREET ADDRESS <u>813 J Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E. Marsh</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wadesbor, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Chavis</u>		14. MOTHER'S MAIDEN NAME <u>Mariah Chavis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carter Mitchell</u>		Address <u>813 J Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 hrs.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m. <u>00</u> 19 <u>57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1956</u> to <u>February 16, 1957</u> that I last saw the deceased alive on <u>February 16, 1957</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>107 N. Main St. Balto 22 Md.</u> DATE SIGNED <u>Feb 22 1957</u>			
ACTUAL SIGNATURE <u>Joseph H. Thomas</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Joseph H. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES R. LAW</u>		ADDRESS <u>802-04 Madison Ave. Balto.</u>	
24a. REC'D BY REGISTRAR <u>Feb 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. Farkas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 20 1957  
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01537

1537

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>617 Wallerson Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Arthur Montooth</b>		4. DATE OF DEATH Month Day Year <b>Feb. 26 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>March 4 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Conductor</b>	
11. BIRTHPLACE (State or foreign country) <b>York Co. Penna</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Barnabas Montooth</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Kenneth Montooth</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Dis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25</b> to <b>Feb. 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 26</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>I EARL PASS</b>		DATE SIGNED <b>2-26-57</b>	
PHYSICIAN'S NAME (Type) <b>I EARL PASS, M.D.</b>		<b>Balto 29 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 1 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Graley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Dickson</b>		24a. REC'D BY REGISTRAR <b>2-28-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Richard Hedrick</b>			

BUREAU V. S.

MAR 1 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>Md</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		TOWN <u>DUNDALK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>30 YRS.</u>		STREET ADDRESS (If rural give location) <u>2487 FAIRWAY</u>		ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN (First) (Middle) (Last) MORAVEC</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-28-57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6/15/1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IND. WRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CZECHOSLOVAKIA</u> ✓	
13. FATHER'S NAME <u>UNK.</u>				14. MOTHER'S MAIDEN NAME <u>SUPLEMENTA UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-5931</u>		17. INFORMANT & ADDRESS <u>SALENA MORAVEC - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>with previous infarction</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (Country) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2, 1956</u> , to <u>2/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/28</u> , 19 <u>57</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above. <u>3/1/57</u>							
SIGNATURE <u>John L. Lobo</u>		M.D. <u>1801 E. 17th St. Baltimore, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>MAR. 1, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Old Town</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John M. Tellyn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Beatty, Dundalk, Md.</u>		ADDRESS	
DATE <u>MAR. 1, 1957</u>							

INSTRUCTIONS

ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BLISSMAN W. S.

1957 4 22

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01539

Reg. Dist. No.

<p style="font-size: 1.5em; margin: 0;">1538</p>							
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BETHLEHEM STEEL CO. HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
				d. STREET ADDRESS <b>1239 Forest Rd. #19</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Moritz</b> Last <b>Moritz</b>				4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 17, 1905</b>	
				9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co. Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Moritz</b>				14. MOTHER'S MAIDEN NAME <b>Anna Sibalik</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Tillie Moritz 1239 Forrest Road-19</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>NONE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> <b>None</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>M.B. Davis M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>				24. REC'D BY REGISTRAR <b>3-27-1957</b> REGISTRAR'S SIGNATURE <i>Dawson L. Furberg</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1M3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

RECEIVED  
FEB 25 1957  
BUREAU V. J.

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

1539

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u> City
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Monkton</u>	<u>3 Mo.</u>	TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Corbett Road</u>		STREET ADDRESS (If rural give location) <u>4304 Fernhill Ave.</u>	

<b>3. NAME OF DECEASED</b> (Type or Print)			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)		
<u>MARIE CLARY NEIGHBOURS</u>			<u>February 21 19 57</u>		
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 17, 1889</u>	<u>67</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>School Teacher</u>		<u>Retired</u>		<u>Mt. Airy, Maryland</u>	
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>		
<u>Henry W. Clary</u>			<u>Elizabeth Begnelle</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>		<u>212-34-3381</u>		<u>John O. Neighbours, Jr., Monkton, Md</u>	

<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>IMMEDIATE CAUSE (A)</b>			<u>Carcinoma of the Colon</u>		<u>6 months</u>
<b>ANTECEDENT CAUSE(S) DUE TO</b>					
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>					
<b>STATING UNDERLYING CAUSE LAST.</b>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>December 1956</u>		<u>Carcinoma of the Colon with extensive metastasis</u>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	

<b>22. I hereby certify that I attended the deceased from... 19 50, to February, 19 57, that I last saw the deceased alive on February 12, 19 57, and that death occurred at 11:45 PM, from the causes and on the date stated above.</b>					
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Willard L. Traub</u>		<u>5101 Gwynn Oak Ave. Baltimore, Md.</u>		<u>Feb. 22, 57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Burial</u>		<u>2/25/1957</u>		<u>St. James Cemetery</u>	
				<u>Monkton Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<u>Feb 23 1957</u>		<u>Eliz. Grouch</u>		<u>Ellsworth Tharmacost</u>	
				<u>4600 Liberty</u>	

**INSTRUCTIONS**

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1539 1-55 10M

RECEIVED

FEB 11 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01541

1540

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6078 Falls Road</u>				/d. STREET ADDRESS <u>6078 Falls Road-Balto. 9, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CONRAD</u> Middle <u>J.</u> Last <u>NEWBAR</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1865</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Record Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Towson Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Newbar</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Mary N. Riggs-2940 Wyman Parkway-Balto. 11</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Art. Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> 19 <u>56</u> to <u>Feb. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 17</u> , 19 <u>57</u> , and that death occurred at <u>2:09</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4037 FALLS RD</u> DATE SIGNED <u>2/19/57</u>							
ACTUAL SIGNATURE <u>Edw. L. Ellassman</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDW. L. ELASSMAN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - North &amp; Pa. Aves.</u>				24a. REC'D BY REGISTRAR DATE <u>2-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

BUREAU V. A.

FEB 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01542

38

1541

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>263 Rodgers Forge Rd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>BARKER</b> Last <b>NORTHEN</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>March 4, 1874</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leonard Barker</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Norris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Miss Ruth Northen - 263 Rodgers Forge Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balt. 17, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 3/1/57</b>		24b. REGISTRAR'S SIGNATURE <b>Matel Krupp</b>	

MEDICAL CERTIFICATION

BONKLAU V. S.

1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1542

## CERTIFICATE OF DEATH

01543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>X2 Raspeburg</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ivy Hall Nursing Home</b>				d. STREET ADDRESS <b>119 N. Harlan St. Baltimore 20</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Matthew</b> Middle <b>J. O'Brien</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1889</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James O'Brien</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Hyland</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Christina Huppman</b> Address <b>Box 305 Gum Spring Rd.</b>				
MEDICAL CERTIFICATION						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Hemiplegia</b> DUE TO <b>Cerebral thrombosis</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 days</b> <b>5 years</b>
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Agatemia, intoxication due to</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
						20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>Aug 27, 1956</b> to <b>Feb 19, 1957</b> , that I last saw the deceased alive on <b>Feb 16, 1957</b> , and the death occurred at <b>11 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Harvey L. Fuller</b> M.D.				ADDRESS (Street, city or town, state) <b>Ridge Road</b>		DATE SIGNED <b>Feb 19/57</b>		
PHYSICIAN'S NAME (Type) <b>HARVEY L. FULLER</b>				<b>Baltimore 6 Ind</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>Edith Hurler</b>		
				DATE <b>FEB 21 1957</b>				

BUREAU V. S.

FEB 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4

1543

## CERTIFICATE OF DEATH

01544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>618 Coleraine Rd</b>		d. STREET ADDRESS <b>618 Coleraine Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Adelaide C. O'Leary</b>		4. DATE OF DEATH Month Day Year <b>Feb. 3, 19 57</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1888</b>
9. AGE (In years last birthday) yrs <b>68</b>		IF UNDER 1 YEAR: Months Days Hours Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Egner</b>		14. MOTHER'S MAIDEN NAME <b>Clara Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Dennis D. O'Leary</b>		Address <b>618 Coleraine Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIO-SCLEROSIS.</b> DUE TO (c) <b>6 DAYS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-4 Yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>0</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>0</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>0</b>		20f. (City or town) (County) (State) <b>0</b>	
21. I certify that I attended the deceased from <b>JAN. 27</b> , 19 <b>57</b> , to <b>FEB. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>FEB. 2</b> , 19 <b>57</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6348 FREDERICK ROAD. CATONSVILLE</b> DATE SIGNED ACTUAL SIGNATURE <b>S. LLOYD JOHNSON</b> M.D. PHYSICIAN'S NAME (Type) <b>S. LLOYD JOHNSON M.D.</b> <b>BALTIMORE 28 MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke,</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>1957 6 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

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REACT

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01545

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1621 Hopewell Ave.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex, Md.</b> d. STREET ADDRESS <b>1621 Hopewell Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>DIANE</b> Middle Last <b>OVERTON</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>20</b> Year <b>19 57</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan 27, 1957</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>21</b>		<b>IF UNDER 1 YEAR</b> Months <b>21</b>		<b>IF UNDER 24 HRS</b> Hours <b>21</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward Overton</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Lecky Brown</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Edward Overton, 1621 Hopewell Ave.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Otitis Media</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b>  <b>NAME (Type)</b> <b>William V. Lovitt, Jr., M.D.</b>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <b>2/20/57</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>2/23/57</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Auburn Cem.</b>				<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> 						<b>ADDRESS</b> <b>918 Wood Hill Ave</b>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> 	
<b>DATE</b> <b>FEB 25 1957</b>													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 25 1957  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1545

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ridgeway Manor 5743 Edmondson</i>		d. STREET ADDRESS <i>512 Glen Allen Drive.</i>	
3. NAME OF DECEASED (Type or print) <i>William E Owens</i>		4. DATE OF DEATH <i>Feb. 12 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 5, 1865</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Owens</i>		14. MOTHER'S MAIDEN NAME <i>Ann Mc Cormick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Mrs. Clara Nichol</i>		Address <i>1609 Kirkwood Rd. 29</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peripheral Vas. Insufficiency (gangrene)</i> <i>450.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1949</i> to <i>Feb 12 1957</i> , that I last saw the deceased alive on <i>2/4/57</i> , and that death occurred at <i>5:10</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lester A. Wall Jr.</i>		ADDRESS (Street, city or town, state) <i>1039 St. Paul St Baltimore Md</i>	
PHYSICIAN'S NAME (Type) <i>LESTER A WALL JR</i>		DATE SIGNED <i>2/15/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/15/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Salem Lutheran</i>		22d. LOCATION (City, town, or county) (State) <i>Catonsville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>	
24a. REC'D BY REGISTRAR <i>Feb 18 '57</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01547

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>513 Murdock Rd.</u>		d. STREET ADDRESS <u>513 Murdock Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>PARKER, Sr.</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1895</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Office machines</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Parker</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Dickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Delphine Parker</u>		Address <u>513 Murdock Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> DUE TO (b) <u>Metastasis to Spine + Lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Baltimore</u>		(County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1955</u> to <u>Feb 2, 1957</u> , that I last saw the deceased alive on <u>Jan 2, 1957</u> , and that death occurred at <u>5:38 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Laurence C. Post</u> M.D. <u>6805 York Rd</u> <u>2-4-57</u> PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u> <u>Baltimore 12 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
24a. REC'D BY REGISTRAR <u>FEB 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

*Continued*

U. S. V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01548

1547

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville - 28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Cedarwood Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>S.P.V.</u> Last <u>PARRISH</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Mayo</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Irma E. Pugh-5 Cedarwood Rd.-Balto. 28, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>56</u> , to <u>2/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Reiter</u>				ADDRESS (Street, city or town, state) <u>3408 Windsor Ave.</u> DATE SIGNED <u>2/22/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>				<u>Baltimore - 16, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner Sons - North &amp; Pa. Aves.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>2-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01549

## CERTIFICATE OF DEATH

1548

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Balto</i>	
CITY OR TOWN <i>Cockeysville</i>		LENGTH OF STAY (In this place) <i>1 month</i>		CITY OR TOWN <i>x Upperco</i>		CITY OR TOWN <i>Falls Rd</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Matthews Ave</i>				STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or Print) <i>Elic May Hale Perego</i>				4. DATE OF DEATH (Month) <i>February</i> (Day) <i>4</i> (Year) <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10 May 1882</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Balto Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Elijah Hale</i>				14. MOTHER'S MAIDEN NAME <i>Sa Wheeler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>daughter - Mrs. Curtis - Cockeysville</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <i>Cancer of pleura of left lung</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>			
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>15 December 1956</i>		19b. MAJOR FINDINGS OF OPERATION <i>mesothelioma of pleura of left lung</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9 Jan</i> , 19 <i>57</i> , to <i>4 Feb</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4 Feb</i> , 19 <i>57</i> , and that death occurred at <i>9:00</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Robert J. Rice</i>		M.D. <i>Cockeysville Md</i>		DATE SIGNED <i>4 Feb 1957</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>2-7-57</i>		NAME OF CEMETERY OR CREMATORY <i>Forest Baptist</i>		LOCATION (City, town, or county) (State) <i>Balto Co Md</i>	
24. REC'D BY REGISTRAR <i>2-6-57</i>		REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Epton - Hampstead Md</i>		ADDRESS	

U. S. A.

1951

1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01550

1549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> <u>Xo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6409 Kriel Avenue</u>				d. STREET ADDRESS <u>1</u> <u>6409 Kriel Avenue #7</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>F.</u> Last <u>PETZ</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>19 57</u>		5. SEX <u>Male-</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Petz</u>				14. MOTHER'S MAIDEN NAME <u>Ethna Gottschaldt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Alice B. Petz-6409 Kriel Avenue - #7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO <u>4-8-57</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>PULMONARY EDEMA + RENAL FAILURE</u> DUE TO <u>HYPERTENSIVE C.V. DISEASE -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>48</u> , to <u>FEB-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 18</u> , 19 <u>57</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		M.D.		ADDRESS (Street, city or town, state) <u>3601 Cypress Rd -</u>		DATE <u>2/20/57</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				<u>Balto 7 - Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tichenor &amp; Sons - North &amp; Pa Ave</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Tom. E. Wheeler</u>			

BUREAU V. B.

FEB 1957

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Item 12 Film 22 4-18-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>402 S. 51<sup>ST</sup> ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>POSINSKI</b> Last		4. DATE OF DEATH Month <b>FEB.</b> Day <b>26</b> Year <b>1957.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 27, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOULDER</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ADALBERT POSINSKI</b>		14. MOTHER'S MAIDEN NAME <b>MICHAELINE NOVAK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-5180</b>	
17. INFORMANT <b>STELLA POSINSKI</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC C.V. DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 MO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ILEOSTOMY DUE TO TUBERCULOUS ABSCESS - 1943</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 12</b> 1957, to <b>Feb 26</b> 1957, that I last saw the deceased alive on <b>Feb 25</b> 1957, and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, City or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Stephen C. Mackowiak</b> M.D. <b>6714 Holabird Ave</b> PHYSICIAN'S NAME (Type) <b>S. C. MACKOWIAK</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-2-57.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>1300 DUNDALK AVE. BALTO, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geiler</b>		24a. REC'D BY REGISTRAR <b>2-27-57</b>	
ADDRESS <b>9015 CONKLING ST. BALTO, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1940 A 3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1551

## CERTIFICATE OF DEATH

01552

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>24 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>W.</b> Middle <b>PRICE</b> Last		4. DATE OF DEATH <b>February</b> Month <b>11</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Somerset County, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNKNOWN</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 18, 1957</b> , to <b>February 11, 1957</b> , that I last saw the deceased on <b>February 11, 1957</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irving Freeman</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/13/57</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 16, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Revell Neck Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802-04 Madison Ave., Balt</b>		24a. REC'D BY REGISTRAR <b>Feb 15-57</b> 24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

FB 1 10

WILLIAM V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01553

Reg. Dist. No.

38

1552

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>			c. LENGTH OF STAY IN 1b <b>? days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Woods nr. Loch Raven Dam</b>				d. STREET ADDRESS <b>2919 Dummery Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM STIRLING PRICE, SR.</b>				4. DATE OF DEATH Month Day Year <b>February 20 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 9. 1893</b>		9. AGE (in years last birthday) <b>63 yrs</b>	IF UNDER 1 YEAR Months Days <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Charger - Beth. Steel Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Annabois Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Price</b>				14. MOTHER'S MAIDEN NAME <b>Susie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II 216-09-5567</b>		17. INFORMANT (Address) <b>Mrs. Beulah V. Price (Wife) 4006 Lyndale Ave. 13</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) (County) (State) <b>nr. Towson Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Levitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Levitt, Jr., M.D.</b>				DATE SIGNED <b>2/21/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25. 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>				24a. REC'D BY REGISTRAR <i>Henry P. Sander</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 25 1957

U. S.

1553

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wayne Aged &amp; Convalescent Home</b>		e. STREET ADDRESS <b>1436 North Rolling Road</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>P.</b> Last <b>PURCELL</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>19th</b> Year <b>1957</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12" 1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander Carns</b>		14. MOTHER'S MAIDEN NAME <b>Emma Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-9204B</b>	
17. INFORMANT <b>George C. Purcell</b>		1436 N. Rolling Road <b>Catonsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1955</b> , to <b>Feb. 19-57</b> , 19____, that I last saw the deceased alive on <b>Feb. 19</b> , 19 <b>57</b> , and that death occurred at <b>2 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Marvin Goldstein</b> M.D. <b>February, 20th 1957</b>			
ACTUAL SIGNATURE <b>Marvin Goldstein</b>		PHYSICIAN'S NAME (Type) <b>Marvin Goldstein</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 23" 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Miller Lane</b>		24a. REGISTERED <b>1957</b>	
24b. REGISTERAR'S SIGNATURE <b>W. J. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1957

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1433

## CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 PINEWOOD ROAD, BALTIMORE 22</u>		d. STREET ADDRESS <u>204 PINEWOOD ROAD BALTIMORE</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>L.</u> Last <u>REHILL</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 27, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>67</u> yn.
11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JULIUS LIEBIG</u>		14. MOTHER'S MAIDEN NAME <u>MINNA GOTTESLEBEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Miss Louise Irene Rehill 204 Pinewood Road Dundalk Md</u>		Address <u>Baltimore 22</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> 2 years (c) <u>Generalized arteriosclerosis</u> 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> to <u>2-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>57</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene F Navy</u> M.D.		ADDRESS (Street, city or town, state) <u>7001 Morningside Rd</u>	
PHYSICIAN'S NAME (Type) <u>Eugene F Navy</u> <u>Dundalk 22, Md</u>		DATE SIGNED <u>Feb 13 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>NORTH EAST, Cecil, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Chant</u>		24a. REC'D BY REGISTRAR <u>John Kelly</u>	
ADDRESS <u>North East, Md</u>		24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01556

1554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Ingleside Ave</u>		d. STREET ADDRESS <u>611 Ingleside Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ESTHER O REICH</u> First Middle Last		4. DATE OF DEATH <u>2/28/57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Shipley</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Elgin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Manuel Reich (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Pulmonic infarct</u> DUE TO (c) <u>Cardio-vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Mon.</u> <u>5 Mon.</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-9-</u> , 19 <u>41</u> , to <u>2-28-</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>2-28</u> , 19 <u>57</u> , and that death occurred at <u>1:46</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. Hening</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>203-Ingleside Ave., Balto. 28-3-2-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert M. Hening M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Torrance</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Habb + Son</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

BUCKING V. S.

RECEIVED  
JAN 10 1900

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01557

1438

## CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1603 Rolling Rd</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marguerite W. Reynolds</b>				4. DATE OF DEATH Month Day Year <b>Feb. 16 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1896</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>R. Brent Walling</b>				14. MOTHER'S MAIDEN NAME <b>Margaret E. Woodward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT Address <b>Mr. N. Edmundson, Reynolds, 1603 Rolling Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Splenic Leukemia</b> 20 4.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diffuse Hemorrhage</b> 2 wks (c) <b>Myocarditis</b> 1 mo							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 2, 1926</b> , to <b>Feb 16 19 57</b> , that I last saw the deceased alive on <b>Feb 12 19 57</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.					ADDRESS (Street, city or town, state) <b>609 Main St Edleridge</b>		
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>					DATE SIGNED <b>2-19-57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke, 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR <b>DATE 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Leo M. Kuffner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 20 1957

BUREAU V. S.

1555  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr10mth26days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Rogers</b>		4. DATE OF DEATH Month Day Year <b>Feb. 26, 1957</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872 Aug. 28</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. H. Rogers</b>		14. MOTHER'S MAIDEN NAME <b>***** Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic carcinoma, breast,</b> (c) <b>(post-operative)</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 25</b> , 19 <b>57</b> , to <b>2-26-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-26-</b> , 19 <b>57</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL</b>			
ACTUAL SIGNATURE <b>David E. Edwards</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DAVID E. EDWARDS</b>		CATONSVILLE 28, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 27 '57</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

1957

RECEIVED



**2411 N. Charles Street, Baltimore**

# 1556 CERTIFICATE OF DEATH

Reg. Dist. No. 30.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Catonsville,</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>gave nearest town</u> TOWN <u>From April 1956</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Harford</u> TOWN <u>Harford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pines</u>		STREET ADDRESS (If rural, give location) <u>16 Fasting Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Franklin</u> (Middle) <u>Ross</u> (Last)		4. DATE OF DEATH <u>Feb. 6</u> (Month) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8/15/1913</u>
9. AGE last birthday <u>41</u> yrs.	10. AGE last birthday If under 1 year Months Days If under 24 hrs Hours Min.	11. BIRTHPLACE (State or foreign country) <u>Bel Air</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jockey</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>David H Ross</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>11-44-108-1000</u>	

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH			
154x Immediate cause (a) Carcinoma of rectum Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last													
(c)													
II. OTHER SIGNIFICANT CONDITIONS													
Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?			
										Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY				(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) OF INJURY		(Hour) m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from July 2, 1956, to Feb. 6, 1957, that I last saw the deceased alive on Feb. 5, 1957, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

SIGNATURE \_\_\_\_\_ (Degree or title) ADDRESS \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

**SIGNATURE**

(Degree or title)

ADDRESS

DATE SIGNED \_\_\_\_\_

### 23. BURIAL, CREMATION

DATE THEREOF \_\_\_\_\_

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)	(State)
----------------------------------	---------

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

~~FEB 19 57~~

Overland

24. FUNERAL DIRECTOR	ADDRESS
Joseph T. Foster & Belier Inc	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 11 1963

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01560

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1557 Item 7 Filmed 3-1-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 5mths29dys		d. STREET ADDRESS 333S. Bentalou St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Rothman		4. DATE OF DEATH Month Day Year February 22 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown Samuel W Richardson		14. MOTHER'S MAIDEN NAME unknown Sarah Pancost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO (b) <u>Cardio Vascular disease</u> DUE TO (c) <u>Closed reduction of fracture + infection</u> 902.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>fracture right hip - Smith Peterson nail + plate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (State as autopsy performed?) <u>fracture right hip - Smith Peterson nail + plate</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 3:05 PM 1-29-57		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on 1-29-57 while getting out of bed; sustaining a frac. right hip.	
20c. TIME OF INJURY Month, Day, Year 1-29-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo M Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. M. Walters</u>		24a. REC'D BY REGISTRAR DATE 25 57	
24b. REGISTRAR'S SIGNATURE <u>Quelan</u>			

THIS DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 5 1957  
BUREAU N. S.

1

INSTRUCTIONS

TO **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The uniform copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01561

1439 **CERTIFICATE OF DEATH**

Reg. Dist. No. 42

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>Md</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>	
TOWN <u>HIGHLANDS</u>		LENGTH OF STAY (in this place)		TOWN <u>HIGHLANDS</u>		TOWN <u>HIGHLANDS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7901 DELAWARE AVE</u>				STREET ADDRESS (If rural give location) <u>7901 DELAWARE AVE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>IRENE</u> (First) <u>RUSSELL</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>FEB</u> (Day) <u>4</u> (Year) <u>1957</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>JULY 25-1876</u>	<b>9. AGE last birthday</b> <u>80</u> yrs.	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AW.</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTO Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>13. FATHER'S NAME</b> <u>WILLIAM WILLIAMS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>—</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Virginia M. Kesner 7901 DELAWARE AVE</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Atherosclerosis</u>				DUE TO (C) <u>16 years</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 11, 1956</u> <b>to</b> <u>Feb 4, 1957</u> , <b>that I last saw the deceased alive on</b> <u>Feb 2, 1957</u> , <b>and that death occurred at</b> <u>11:45 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Paul D. Humphreys</u>		<b>ADDRESS</b> (Street, city, town, state) <u>3301 Campbell St BALTO Md</u>		<b>DATE SIGNED</b> <u>2/5/57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>FEB 7-1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet Cem</u>		<b>LOCATION</b> (City, town, or county) (State) <u>BALTO Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>FEB 8 1957</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Dr. Hugh M. Kuffner</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter B. Walters</u>		<b>ADDRESS</b> <u>Pratt &amp; Strickland</u>	

BUREAU V. S.

EEB

RECEIVED

1558

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MATTHEW ALBERT RUTTER</b>		4. DATE OF DEATH Month Day Year <b>February 2 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/1883</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER A YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S. MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>by birth.</b>	
13. FATHER'S NAME <b>EDWARD RUTTER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE LYNCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pulmonary infarction and thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 25, 1957</b> , to <b>Feb 2, 1957</b> , that I last saw the deceased alive on <b>Feb 2, 1957</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachler</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-4-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>FEB. 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Verner Summer</b>		24a. REC'D BY REGISTRAR <b>Feb 5 '57</b>	
ADDRESS <b>4609 Park Heights Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 2

RECEIVED



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01563

## 1434 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO.		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL OR and give nearest town) DUNDALK 22		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1911 PENHALL RD.				STREET ADDRESS (If rural give location) 1911 PENHALL RD.			
3. NAME OF DECEASED (Type or Print) (First) GENEVIEVE (Middle) LEE (Last) SANDRIDGE				4. DATE OF DEATH (Month) 2 (Day) 17 (Year) 1957			
5. SEX FEM	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAR. 2. 1913	9. AGE last birthday 43 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS F. SEARS				14. MOTHER'S MAIDEN NAME NORA R. LYNCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) NO		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS J.L. SANDRIDGE - SAME			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
171X IMMEDIATE CAUSE (A) CA of Cervix				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-15, 1957, to 2-17, 1957, that I last saw the deceased alive on 2-16, 1957, and that death occurred at 7:10 P.M. from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/20/57		NAME OF CEMETERY OR CREMATORY CUCKER SPRINGS		LOCATION (City, town, or county) (State) WEBSTER SPRINGS W. VA	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Jm. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 2-2-1957				Address of Burial - Dundalk, Md.			

INSTRUCTIONS

TO FURNISHING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The softform copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A19C 1-55 10M

How

BUREAU A. B.

FEB 9 1957

RECEIVED

1559

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Myrth Ave.</u>				d. STREET ADDRESS <u>808 Myrth Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Sauer</u>				4. DATE OF DEATH Month Day Year <u>February 5, 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 16, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Micheal Sauer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 3, 1955</u> to <u>Feb 5, 1957</u> that I last saw the deceased alive on <u>Feb 4, 1957</u> , and that death occurred at <u>9 15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.				ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u>		DATE SIGNED <u>2/6/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Brudzinski</u>				ADDRESS <u>L407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>2/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frank Hurley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

77

BUREAU V. S.

FEB 13 1967

RECEIVED

1560

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER 20</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>IVY HALL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>L.</b> Last <b>SAYWELL</b>		4. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 31, 1973</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>WM. R. SAYWELL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MACNEILL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>717-09-8346</b>	
17. INFORMANT <b>MRS. BYRON S. SCHWARTZ - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>181X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of bladder</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/3</b> , 19 <b>57</b> , to <b>2/6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/5</b> , 19 <b>57</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. L. Kolodny MD</b>		ADDRESS (Street, city or town, state) <b>1725 EASTERN BLVD BALTIMORE 21, MD</b>	
PHYSICIAN'S NAME (Type) <b>A. L. Kolodny MD</b>		DATE SIGNED <b>FEB 6 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWVIEW CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>AMHERST, N. H.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Pinkie Bradley Dundalk, MD</b>		24a. REC'D BY REGISTRAR <b>Edith Hurley</b>	
ADDRESS		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4.

MAY be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOOK NO. 1

1950-1951

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1561

## CERTIFICATE OF DEATH

01566

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD J. Schenning SR.</b>				4. DATE OF DEATH Month Day Year <b>2 - 20 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-27-1905</b>	
9. AGE (In years last birthday) <b>51</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK-OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>HENRY Schenning</b>			
14. MOTHER'S MAIDEN NAME <b>FUNK</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>216-01-4752</b>			
16. SOCIAL SECURITY NO. <b>216-01-4752</b>				17. INFORMANT <b>EMMA (WIFE)</b> Address <b>SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 18, 19 57</b> to <b>Jan 25, 19 57</b> , that I last saw the deceased alive on <b>Jan 25, 19 57</b> , and that death occurred at <b>4 AM</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>3501 FAIR AVE</b> DATE SIGNED <b>John G. Connelly</b>			
ACTUAL SIGNATURE <b>John G. Connelly</b> M.D.				PHYSICIAN'S NAME (Type) <b>John G. Connelly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED-HEART</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b> ADDRESS <b>Essex - Md.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The low equi that the death certificate executed within 24 hours after death. Page 4

RECEIVED  
FEB 25 1957  
BUREAU V. S.



1

INSTRUCTIONS

TO THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01567

## CERTIFICATE OF DEATH

1562

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>		CITY <u>Baltimore</u>	
CITY <u>Towson</u>		LENGTH OF STAY (in this place) <u>Approx. 2 yrs</u>		CITY <u>Towson</u>		CITY <u>Baltimore</u>	
TOWN <u>Towson</u>				TOWN <u>Towson</u>		TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Maris Hospice</u>				STREET ADDRESS <u>Stella Maris Hosp.</u>			
				ADDRESS <u>3629 WALKER AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emma</u>		(Middle) <u>Caroline</u>		(Last) <u>Schulz</u>		(Month) <u>Feb.</u>	
						(Day) <u>1</u>	
						(Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 21, 1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Imbold</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS <u>Mrs. C. E. Berndt - 206 E. Lake Ave.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
181x IMMEDIATE CAUSE (A) <u>Carcinoma of Bladder</u>				1 yr.			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-</u>				1			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal Vascular Dis-</u>				10 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-1-57</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> to <u>Feb. 1, 1957</u> that I last saw the deceased alive on <u>Feb. 1, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. J. Ticknew</u>				DATE SIGNED <u>Feb 21, 1957</u>			
ADDRESS (Street, city, town, state) <u>7501 Park Rd. Baltimore, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/57</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 4 1957</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Ticknew</u>		ADDRESS <u>7501 Park Rd. Baltimore, Md.</u>	

U.S. DEPT. OF JUSTICE

RECEIVED

1563

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5501 Forest Park Ave.</u>		d. STREET ADDRESS <u>5501 Forest Park Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>CARRIE</u> Last <u>SEEBO</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Jacob Graf</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Trotenbrodt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Margaret Reed - 5501 Forest Park Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension C. V. Disease</u> <u>170 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Bypass</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>34</u> , to <u>Feb 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 8</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>172946 Fayette St 2/9/57</u>			
ACTUAL SIGNATURE <u>Walter S. Smith</u> M.D.			
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner &amp; Sons - Balto 17th</u>		24a. REC'D BY REGISTRAR DATE <u>1-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1564

## CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cedar Knoll Rd.</b>				e. STREET ADDRESS <b>Cedar Knoll Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Idora</b> Middle <b>S.</b> Last <b>Shipley</b>				4. DATE OF DEATH Month <b>2-16-57</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-1864</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min <b>92</b>		IF UNDER 24 HRS Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min <b>92</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Brice MacKindry Shipley</b>				14. MOTHER'S MAIDEN NAME <b>Jane Buckingham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Harry V. Shipley, Jr., Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric hemorrhage</b> DUE TO <b>Gastric ulcer</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Probably carcinoma stomach</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>8 pm</b> <b>8 pm.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cholelithiasis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cockeysville, Md.</b>				20g. (County) <b>Cockeysville, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July 1956</b> to <b>Feb 16 1957</b> , that I last saw the deceased alive on <b>Feb 16 1957</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D.				ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>				DATE SIGNED <b>2/16/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>2-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 2, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>				ADDRESS <b>622 York Rd. Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>Frank Smith</b>	
24b. REGISTRAR'S SIGNATURE <b>Frank Smith</b>				DATE <b>20 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1905

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1565

CERTIFICATE OF DEATH

01570

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 353, Philadelphia Road</b>				d STREET ADDRESS <b>Box 353, Philadelphia Road.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY OLIVIA SHIPLEY</b>				4. DATE OF DEATH Month Day Year <b>February 26, 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1883</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Green</b>				14. MOTHER'S MAIDEN NAME <b>Barbara E. Schepleng</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Annie Williams Box 353, Philadelphia Road.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>2 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 22, 1957</b> to <b>Feb 26, 1957</b> that I last saw the deceased alive on <b>Feb 26, 1957</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Baumgardner M.D.</b>				ADDRESS (Street, city or town, state) <b>Baltimore Md</b>		DATE SIGNED <b>2/27/57</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>3/1/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 4 1957

BUREAU V. S.



1566

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Earle L. Simpson</b>				4. DATE OF DEATH <b>Feb. 11/57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1898</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Simpson</b>				14. MOTHER'S MAIDEN NAME <b>Edna Albaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>214 14 1804</b>		17. INFORMANT <b>Mrs. Lola Simpson (WIFE)</b> Address <b>505 Wildwood PKWY</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Hemorrhage</b> <b>Esophageal Varicosities</b> <b>Faure's Cirrhosis, Liver</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>6 mo</b> <b>5 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>NOV. 5, 1956</b> to <b>FEB. 11, 1957</b> , that I last saw the deceased alive on <b>FEB. 10, 1957</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above							
ACTUAL SIGNATURE <b>John F. Schaefer</b> M.D.				ADDRESS (Street, city or town, state) <b>401 RANDOM RD. BALTO. 29 MD.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER</b>				DATE SIGNED <b>FEB. 12, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn 7, Balto. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b> ADDRESS <b>4101 Edmondson Ave</b>				24a. REC'D BY REGISTRAR <b>FEB 14 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01572

1567

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cummings Mills</u>				c. LENGTH OF STAY IN 1b <u>34 1/2 hrs 11 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 29</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Tr. Sch.</u>				d. STREET ADDRESS <u>1015 St Charles Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>William</u> Last <u>Skelpsa</u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-47</u>	
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.		IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Vincent A. Skelpsa</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Judith Naragaskis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records Rosewood Cummings Mills Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 758.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypochondrodystrophy (Hurler's Dis.)</u> DUE TO (c) <u>since birth</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>Feb 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 9</u> , 19 <u>57</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood, Cummings Mills, Md</u> DATE SIGNED <u>7/6/57</u>							
ACTUAL SIGNATURE <u>Vincent Barrett Johns</u>				PHYSICIAN'S NAME (Type) <u>M.D. Rosewood, Cummings Mills, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-13-57</u>		<u>MOST HOLY REDEEMER</u>		<u>BE LAIR RD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. W. Kucharskas</u>				ADDRESS <u>703 McKing St #30</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>							

REAU V. S.

FEB 7 1904

EGEY V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01573

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>				c. LENGTH OF STAY IN 1b <b>XO White Marsh</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>/ Red Lion Rd</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Hall</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-2-08</b>		9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mch. Pump Man Cities Services Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert X. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 11/4/43* 45</b>				16. SOCIAL SECURITY NO. <b>Frances Smith Red Lion Rd White Marsh</b>			
17. INFORMANT <b>Md.</b>				Address <b>White Marsh</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crush Injuries head and chest</b> DUE TO <b>Auto Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Auto Accident</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident---collision</b>			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 40</b>		20f. (City or town) (County) (State) <b>White Marsh Balto Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John C. Hyle</b>				DATE SIGNED <b>2-7-57</b>			
EXAMINER'S NAME (Type) <b>John C. Hyle</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holtmann Funeral Home 3218 Hudson St.</b>				24a. REC'D BY REGISTRAR <b>DATE 2-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Walter H. Henshaw</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 7 File 22 2-25-57 et  
**CERTIFICATE OF DEATH**

01574

Reg. Dist. No.

1569

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Conv. Home</u>		d. STREET ADDRESS <u>2525 Old Frederick Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Eatherine E. Snair</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1911</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Adam Snair</u>		14. MOTHER'S MARRIED NAME <u>  </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Joseph Krager</u>		Address <u>2525 Old Frederick Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vasc Disease</u> DUE TO (c) <u>Ast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 - Intestinal Obstruction</u> (b) <u>2 - Old Fracture RT Hip Surgery</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/6</u> , 1957, to <u>2/19</u> , 1957, that I last saw the deceased alive on <u>2/14</u> , 1957, and that death occurred at <u>1:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff J.</u> M.D.		DATE SIGNED <u>2/2/57</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		ADDRESS (Street, city or town, state) <u>4605 Edmondson ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Habb 7 Son - Catonsville</u>		24a. RECEIVED BY REGISTRAR DATE <u>FEB 25 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

RECEIVED

FEB 25 1957

BUREAU V. S.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

01575  
33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>5 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntingdon Valley</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reisterstown Road</b>				d. STREET ADDRESS <b>339 Felix Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roy William Speechley</b>				4. DATE OF DEATH Month Day Year <b>Feb. 22 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1900</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive at Thompson Traylor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Stanford Speechley</b>				14. MOTHER'S MAIDEN NAME <b>Hueber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>166-07-3551</b>		17. INFORMANT Address <b>Earl S. Speechley, Huntingdon Valley, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO 4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-23-57</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>2-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. S. Line</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 2 1957  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01576

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> c. LENGTH OF STAY IN lb <b>3 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7 Bel Haven Drive</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> d. STREET ADDRESS <b>7 Bel Haven Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nelson B. Spicer</b>		4. DATE OF DEATH Month Day Year <b>February 17, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1893</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric Welder</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Spicer</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-7528</b>	
17. INFORMANT <b>Mrs. Della E. Spicer</b>		Address <b>7 Bel Haven Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUN SHOT WOUND Thru Left</b> DUE TO (b) <b>Chest (12 Gauge)</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot Self Thru L. Chest @ 12 Gauge SHOT Gun</b>	
20c. TIME OF INJURY Month, Day, Year <b>2-17-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Overlea - Balto Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis M.D.</b>		DATE SIGNED <b>2-19-57</b>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 20, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Christian</b>	22d. LOCATION (City, town, or county) (State) <b>Joppa, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Korabur Funeral Home</b>		24a. REC'D BY REGISTRAR <b>FEB 21 1957</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. A. L. Rappesbury</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1, 2, and 3 with the Registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01577

1572

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN lb <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ivy Hall Nursing Home</b>		e. STREET ADDRESS <b>Box 480 Rt. 14 Carroll Island Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Clayton</b> Middle <b>E.</b> Last <b>Steinacher Sr.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1898</b>
9. AGE (In years birth day) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baugh Chem. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward W. Steinacher</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Grimm</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-07-9837</b>		17. INFORMANT <b>Anna Steinacher</b> Address <b>Box 480 Rt. 14 Carroll Island Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO (b) <b>162X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>1 year</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/17</b> , 1956, to <b>2/8</b> , 1957, that I last saw the deceased alive on <b>2/7</b> , 1957, and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. L. Kolodny</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>1825 Eastern Rd. Balto., Md. 2/9/57</b>	
PHYSICIAN'S NAME (Type) <b>A. L. Kolodny</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-11-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Meth. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Larsen Funeral Home 7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>Edith Hurley</b>	

PHILADELPHIA V. S.

—R. 16 177

PAID

PAID TO THE ORDER OF THE



J. A. S.

1877



72  
J. A. S. : 1877



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
TO MARRIED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01579

1574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>34 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>111 Albemarle Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>B.</b> Last <b>STOUFFER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1915</b>
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Warren Stouffer</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Buckingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>220-01-0840</b>	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE AND PULMONARY EDEMA, 470x BILATERAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MALIGNANT MELANOMA, MULTIPLE METASTASIS</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 22, 1957</b> , to <b>February 25, 1957</b> , and that death occurred at <b>5:55 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rolando P. Ponce de Leon</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>2/26/57</b>	
PHYSICIAN'S NAME (Type) <b>ROLANDO P. PONCE de LEON, M.D., VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-28-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd. Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>DAVID L. FARLEY</b> 24b. REGISTRAR'S SIGNATURE <b>DAVID L. FARLEY</b>	

BUREAU V. S.

REC'D TEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1575

CERTIFICATE OF DEATH

01580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale Rd.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8325 Philadelphia Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>STREIT</u> Last <u>STREIT</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u> Hours <u>58</u>	IF UNDER 24 HRS Months <u>10</u> Days <u>14</u> Hours <u>58</u>	Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gustav Streit</u>				14. MOTHER'S MAIDEN NAME <u>Antonia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>none</u>		17. INFORMANT Address <u>Gustav Streit (brother) 8325 Philadelphia Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 min 58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN.</u> , 195 <u>2</u> , to <u>FEB. 20</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>FEB. 20</u> , 195 <u>7</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James R. Mason, M.D.</u> M.D. <u>8019 Philadelphia Road</u> PHYSICIAN'S NAME (Type) <u>James R. Mason M.D.</u> <u>Baltimore 6, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Greenmount Ave &amp; North Aves.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>				ADDRESS <u>2601-03-05 E. Madison</u>		24a. REC'D BY REGISTRAR <u>FEB 25 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

RECEIVED  
FEB 2 1917  
BUREAU V. S.

1576  
CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tower Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>F.</b> Last <b>STRICKLER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Edward Strickler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Katherine (Poulton)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Irvin L. Strickler-Tower Rd., Randallstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial Insufficiency</b> DUE TO <b>arteriosclerotic heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2/4/57</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/18/57</b> to <b>2/4/57</b> , that I last saw the deceased alive on <b>2/4/57</b> , and that death occurred at <b>107 E. West St. Balto 30, Md.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. S. ELLISON</b> M.D.		DATE SIGNED <b>2/8/57</b>	
PHYSICIAN'S NAME (Type) <b>E. S. ELLISON</b>		ADDRESS (Street, city or town, state) <b>Balto 30, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/11/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickener &amp; Sons - Balto, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 13 1957</b>	
ADDRESS <b>Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. E. Martin</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 1 1971  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1577

## CERTIFICATE OF DEATH

01582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr8mth26dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>MABEL</b> Last <b>Sunderland</b>		4. DATE OF DEATH <b>February 16</b> 19 <b>57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1898</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher - housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Marion Irvin</b>		14. MOTHER'S MAIDEN NAME <b>Anna Bodine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C. U. A</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> (c) <b>lung disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 14, 1957</b> , to <b>Feb. 16, 1957</b> , that I last saw the deceased alive on <b>Feb. 16, 1957</b> , and that death occurred at <b>8 1/2 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Gertrude J. Fleischmann</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2.16.1957</b>	
PRINTED NAME (Type) <b>GERTRUDE J. FLEISCHMANN</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Witcher Hwy Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lowman</b>		24a. REC'D BY REGISTRAR <b>901 Hollis</b>	
24b. REGISTRAR'S SIGNATURE <b>Feb 19 57</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED A. S.

1957





## 1578 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>John Taylor</b>		2. DATE OF DEATH <b>2/18/57</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore County</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Marshy Point Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Chase, Maryland</b>	
c. Length of stay in Baltimore <b>5</b> Yrs. <b>11/11/51</b> Mths. <b>11</b> Days		D. STREET ADDRESS (If rural, give location) <b>Marshy Point Road</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>65</b>
9. AGE (in years last birthday)		10. NUMBER 1 Year Months Days	11. UNDER 24 Hours Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Wilbert Taylor</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. INFORMANT <b>Daisy Ellis</b>		ADDRESS <b>Same</b>	
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral apoplexy Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardio-Vascular Disease</b>		DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY		21B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>Feb 18, 1957</b> , that I last saw the deceased alive on <b>Feb 18, 1957</b> and that death occurred at <b>9 A. m.</b> , from the causes and on the date stated above.		21F. HOW DID INJURY OCCUR	
23A. SIGNATURE <b>J. M. Baumgardner M.D.</b>		23B. ADDRESS <b>Bueto 6 Md</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>2/24/57</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md. A.H.C.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Feb 23-1957</b>		REGISTRAR'S SIGNATURE <b>R. W. Dawson</b>	
25. FEDERAL DIRECTOR <b>L. F. Taylor</b>		ADDRESS <b>Chas. O. Wilcox 1000 Brantley Ave</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 22 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01584

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>17 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harris Mill Rd.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>			
3. NAME OF DECEASED (Type or print) <u>Martha Emma Taylor</u>				f. STREET ADDRESS <u>Harris Mill Rd.</u>			
4. DATE OF DEATH <u>February 7 1957</u>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. UNDER YEAR <u>38</u> Months		11. IF UNDER 24 HRS. <u>38</u> Days		12. IF UNDER 24 HRS. <u>38</u> Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory Dauphin Co., Pa.</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>199-220771</u>			
17. INFORMANT <u>Mrs. Carl Tracy</u>				Address <u>White Hall Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXA NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bowers Cemetery</u>	
22d. LOCATION (City, town, or county) <u>New Freedom, Penna.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac H. Hertenstein</u>				ADDRESS <u>New Freedom Pa.</u>		24a. REC'D BY REGISTRAR <u>2/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles G. Friction</u>			

RECEIVED

1957

RECEIVED

1580

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN RURAL</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON RURAL XI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HANOVER PIKE</u>				d. STREET ADDRESS <u>MT. CARMEL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Ellen Thompson</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 13 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>CARROLL THOMPSON PARKTON MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> 4400 DUE TO (b) <u>Hypertensive Cardio-Vascular Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>JAN 1</u> 19 <u>56</u> to <u>FEBRUARY 13</u> 19 <u>57</u> , that I last saw the deceased alive on <u>February 13</u> 19 <u>57</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>2/13/57</u> ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. <u>—</u> PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> <u>Hampstead Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr 16 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery Parkton Balto. Co. Md.</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom Pa.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Eline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01586

1440

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY in 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4136 Wilkens Avenue</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Arbutus</b>			
f. STREET ADDRESS <b>4136 Wilkens Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mamie First P. Middle Thompson Last</b>				4. DATE OF DEATH <b>February 12, 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 19, 1889</b>	
9. AGE (In years and birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>57</b> Min <b>19</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Belair, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John H. Cox</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Albaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles E. Thompson</b> Address <b>4136 Wilkens Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December, 1956</b> , to <b>Feb. 12, 1957</b> , that I last saw the deceased alive on <b>Feb. 10, 1957</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>D. C. MacLaughlin</b> M.D.				ADDRESS (Street, city or town, state) <b>4508 Edmondson Village</b>		DATE SIGNED <b>2/14/57</b>	
PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin, M.D.</b>				Baltimore 29, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>				24a. REC'D BY REGISTRAR DATE <b>2/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Jas. Krueger</b>	

J. V. C.

20

1911



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01587

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>		c. LENGTH OF STAY IN 1b <b>emp. 20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore- 341-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sagamore Farms</b>				d. STREET ADDRESS <b>2805 Elsinor Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>J.</b> Last <b>Tittle</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 1, 1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groom</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Race Horsing</b>		11. BIRTHPLACE (State or foreign country) <b>Melvale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217-07-5623</b>		17. INFORMANT <b>Susan Tittle, 2805 Elsinor Ave., Balto.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>none</b> (County) <b></b> (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>2-18-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Gilmore, 519 Mosher St.</b>				24a. REC'D BY REGISTRAR <b>Feb 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elmer</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

U. S. AIR FORCE

18

U. S. AIR FORCE

1582

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN It <b>Pyromthllyds</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>3712 Parkside Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>A.</b> Last <b>Tomlinson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>57</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Dunigan</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Dunigan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOS ITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myccardial infarction</b> <b>420.1</b> DUE TO <b>Corcnary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 28, 1957</b> , to <b>Feb. 28, 1957</b> , that I last saw the deceased alive on <b>February 28, 1957</b> , and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 3-1-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/5/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickener &amp; Sons - Balto. 17 Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Qu...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 of 4

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

GEORGE VANDERBILT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01589

1583

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>17 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5808 Westwood Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>E.</b> Last <b>Tormollan</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1914</b>
9. AGE (In years last birthday) yrs <b>42</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman Reinhardt</b>		14. MOTHER'S MAIDEN NAME <b>Ernestina Loessin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-01-1851</b>	
17. INFORMANT <b>Mr. Owen E. Tormollan Jr.</b>		Address <b>5808 Westwood Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Coma</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intercapillary Glomerular Sclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-7 Hour</b> <b>1 year</b> <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-15</b> , 19 <b>57</b> , to <b>2-2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-2-57</b> , 19 <b></b> , and that death occurred at <b>12:11 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul G. Mueller</b>		ADDRESS (Street, city or town, state) <b>6331 Belair Rd.</b>	
PHYSICIAN'S NAME (Type) <b>Paul G. Mueller M.D.</b>		DATE SIGNED <b>2/3/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jerusalem Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Miss A. L. Rupprecht</b>	

134

رأيت في المنام  
أنني قد كنت  
في الجنة مع  
الأنبياء والمرسلين

بسم الله الرحمن الرحيم

الحمد لله الذي هدانا لهذا

الذي كنا في ضلال

عن هذا

الحمد لله

الذي هدانا لهذا

الذي كنا في ضلال

عن هذا

بسم الله الرحمن الرحيم

الحمد لله الذي هدانا لهذا

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01590

1584

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1612 Providence Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Providence</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence</b> d. STREET ADDRESS <b>1612 Providence Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>M.</b> Last <b>Treadwell</b>		4. DATE OF DEATH <b>Feb.</b> Month <b>15</b> Day <b>1957</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Black &amp; Decker Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Treadwell</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Nonn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-05-8247</b>	
17. INFORMANT <b>Mrs. Hazel Cranston</b>		Address <b>1612 Providence Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiac-Renal</b> DUE TO (c) <b>Vascular Disease</b> <b>15 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1957</b> to <b>Feb 7, 1957</b> , that I last saw the deceased alive on <b>Feb 7, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		ADDRESS (Street, city or town, state) <b>7501 York Rd</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Providence Meth. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lillian T. H. H.</b> ADDRESS <b>7401 Balto Rd.</b>		24a. REC'D BY REGISTRAR <b>Feb 18 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Markel Gray</b>	

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U. S. DEPT. OF JUSTICE



1585  
CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <b>md</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JEWELL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE ST. H.</b>		d. STREET ADDRESS <b>7</b>	
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>TURNER</b> Last <b>TURNER</b>		4. DATE OF DEATH Month <b>2</b> / Day <b>14</b> / Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>BENJAMIN FRANK ARMINGER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH E. HARRISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> DUE TO <b>Advanced Senile Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>210X</b> DUE TO (b) <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① - Adeno-Ca. of Bladder ② Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 6, 1940</b> , to <b>Feb 14, 1957</b> , that I last saw the deceased alive on <b>Feb 14, 1940</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles Ward</b>		ADDRESS (Street, city or town, state) <b>Spring Grove Hosp, Catonsville 28, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. CHARLES WARD</b>		DATE SIGNED <b>FEB 14 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Feb 17, 1957</b>	<b>Smithville</b>	<b>Dunkirk Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm H. Hutchins</b>		ADDRESS <b>Owings Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 2-15-57</b>		24b. REGISTRAR'S SIGNATURE <b>N. W. Ward</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01592

1586

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Rainier, Maryland 16-</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3252 Queenstown Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Hugh</b> Last <b>Ullery</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN Newton Ullery</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Becky Booth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>1898</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMATION <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>1446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile arteriosclerotic nephrosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 24, 1956</b> , to <b>Feb. 1, 1957</b> that I last saw the deceased alive on <b>Feb. 1, 1957</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-1-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Chambers Co</b>		ADDRESS <b>1400 - Chapin St</b>	
24a. REC'D BY REGISTRAR <b>FEB 6 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Chambers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach this certificate from the carbon copy. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1958

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01593

## Reg. Dist. No.

1587

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>70 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>417 York Road</b>		d. STREET ADDRESS <b>417 York Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M.</b> Last <b>Urban</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1860</b>
9. AGE (In years last birthday) <b>97 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>-----</b>	
13. FATHER'S NAME <b>Theodore A. Bokel</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Schroeder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(? yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Miss Marguerite B. Urban</b>		Address <b>417 York Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>-----</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>1955</b> , 19 <b>55</b> , to <b>FEB 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>FEB 19</b> , 19 <b>57</b> , and that death occurred at <b>5:30</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 W. PENNA. AVE</b> DATE SIGNED <b>2/21/57</b> ACTUAL SIGNATURE <b>T.C. Siwinski</b> M.D. <b>TOWSON 4 MD.</b> PHYSICIAN'S NAME (Type) <b>T.C. SIWINSKI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Gowans Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Meeks</b>		24a. REC'D BY REGISTRAR DATE <b>2-21-57</b>	
ADDRESS <b>Don 805 N. Calvert St.</b>		24b. REGISTRAR'S SIGNATURE <b>Maebel Green</b>	

U. S.

FEB 25 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1588

## CERTIFICATE OF DEATH

01594

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>14 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3006 Lavender Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C</b> Last <b>Vaughan</b>		4. DATE OF DEATH Month <b>2</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1882</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM VAUGHAN</b> <del>unknown</del>		14. MOTHER'S MAIDEN NAME <b>ANNIE FEENEY</b> <del>unknown</del>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>133-10-1947</b> <del>unknown</del>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic</b> (c) <b>Senile/nephrosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 15</b> , 19 <b>57</b> , to <b>2/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2/26</b> , 19 <b>57</b> , and that death occurred at <b>8:40 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
DATE SIGNED <b>2/26/57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-1-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F EVANS &amp; SON</b>		ADDRESS <b>8802 HARTFORD RD</b>	
24a. REC'D BY REGISTRAR <b>DATE 2/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>A. W. Dedrick</b>	

MADE IN U.S.A.

1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1589 CERTIFICATE OF DEATH

01595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>1 Hour- 10 M.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1224 Dukeland Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>VAUGHN</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 4, 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevadore</b>		11. BIRTHPLACE (State or foreign country) <b>Essex County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE LEPTOMENINGITIS</b> <b>340.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 14, 1957, to February 14, 1957</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/15/57</b>							
ACTUAL SIGNATURE <b>Rolando D. Ponce de Leon</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>ROLANDO D. PONCE de LEON, M.D. VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore 1, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>	

RECEIVED

FEB 20 1957

BUREAU V. B.

1590

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wayne Conv Home</u>		e. STREET ADDRESS <u>6603 Johnny Cake Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>VIVIAN</u> Middle <u>VICK</u> Last <u>VICK</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shockbrakes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Tobias Vick</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr Eugene J. Gerberg (same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>BIX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Small Strokes old with residual Aphasia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1956</u> to <u>Feb 1957</u> , that I last saw the deceased alive on <u>2/21/57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Mc Grath M.D.</u>		DATE SIGNED <u>2/22/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D. Catonsville 28 md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Nathan</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 25 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 25 1967  
BUREAU V. S.

## 1591 CERTIFICATE OF DEATH

01598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 280</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Madge Way Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER W. WADE</u>		4. DATE OF DEATH <u>2/8/57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1901</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>15</u> Hours <u>19</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garcia Elec Co</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Upton</u>		14. MOTHER'S MAIDEN NAME <u>Fowler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-injury primary infection</u> (c) <u>1955</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 weeks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:15</u> , 19 <u>56</u> , to <u>Feb 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-5-57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE-SIGNED, <u>2-8-57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. H. H. H. H.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Balto md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb + Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

REDAU V. S.

1957

1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1592

## CERTIFICATE OF DEATH

01599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOROTHEA M. WAGNER</u>		4. DATE OF DEATH <u>2/14/57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Ruppel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Foreythe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. J. Wagner Sr. (Same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maternal to Shive Vessel</u> <u>171X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO <u>Coronary artery disease</u> (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 yrs</u> <u>2 hrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1956</u> , to <u>Feb 14, 1957</u> , that I last saw the deceased alive on <u>Feb 14, 1957</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
SIGNATURE <u>J. Chas. Norton</u> M.D.		3605 <u>Mc.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/18/57</u>	<u>London Park</u>	<u>Balto. md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Math + Son</u>		24a. REG'D BY REGISTRAR DATE <u>FEB 19 57</u>	
ADDRESS <u>28</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Norton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 170000

101 E.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1593

CERTIFICATE OF DEATH

01600

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RESIDVILLE</u>		c. LENGTH OF STAY IN 1b <u>10 mths.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Hawthorne Ave-</u>		d. STREET ADDRESS <u>W. MAIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES Woodward Walker</u>		4. DATE OF DEATH <u>FEB-24-</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Stanton, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adopted by Walker Family</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-4647B-</u>	
17. INFORMANT <u>Mrs. Ann E Rhoads - 194 Hawthorne Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Art. Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3-4 yrs.</u> (c) <u>3-4 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN.</u> 19 <u>53</u> , to <u>FEB 24, 1957</u> , that I last saw the deceased alive on <u>FEB. 24</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reist Rd., Pikeville, Md.</u> DATE SIGNED <u>2/24/57</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.H. Russell</u>		24a. REC'D BY REGISTRAR <u>REC'D BY REGISTRAR</u> 24b. REGISTRAR'S SIGNATURE <u>Moorthy Hewells</u>	

BURNETT A. A.

1937

78

RECEIVED  
JUL 15 1937

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1594

## CERTIFICATE OF DEATH

01601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>No record (M.R.L. City Hosp)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Warminski</b> Last <b>Warminski</b>		4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1899</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>XXXXXX Peter Warminski</b>		14. MOTHER'S MAIDEN NAME <b>XXXXXX Bronislawa Mastrowicz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO <b>Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO <b>---</b> (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 22, 1957</b> , to <b>Feb. 22, 1957</b> , that I last saw the deceased alive on <b>Feb. 22, 1957</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-23-57</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		Catonsville 28, Maryland <b>2/23/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Feb. 25, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b> ADDRESS <b>2829 Hudson St. Balto 24, MD</b>		24a. REC'D BY REGISTRAR <b>FEB 26 57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

-B-

RECEIVED

01602

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 1595 CERTIFICATE OF DEATH

Reg. Dist. No. 4

20

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Catonville</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pine N. H.</u>		STREET ADDRESS (If rural, give location) <u>541 Yale Ave</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>C.</u> (Last) <u>Wayson</u>		DATE OF DEATH <u>Feb - 24 - 1957</u>	
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-24-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Michael Euegan</u>		14. MOTHER'S MAIDEN NAME <u>Ida Kinslow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Louis Sweetman - 541 Yale Ave Balt. Md.</u>			

## 13. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

411 Immediate cause (a)....

Antecedent cause(s) (b).... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

General Carcinoma of

Cervix of Uterus

## INTERVAL BETWEEN ONSET AND DEATH

27 Mos

14 Mos

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 23, 1956, to Feb 24, 1957, that I last saw the deceased alive on 2/22, 1957, and that death occurred at 6:30 P. m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-27-57</u>	<u>Repley Hill</u>	<u>Southland Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 24 1957</u>	<u>Dr. J. J. Senese</u>	<u>J. W. E. Hester</u>	<u>Wash. D. C.</u>

MARGIN RESERVED FOR BURNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. 1957

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1596

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>3 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3401 4</b> d. STREET ADDRESS <b>2257 Cecil Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALPHONSO W. WHITE</b>				4. DATE OF DEATH Month Day Year <b>February 26 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 17, 1923</b>	
9. AGE (in years last birthday) yrs <b>33</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Groc. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Paces, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Luther White</b>			
14. MOTHER'S MAIDEN NAME <b>Fannie Mosley</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			
16. SOCIAL SECURITY NO. <b>230-20-2810</b>				17. INFORMANT Address <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TUBERCULOUS MENINGITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY TUBERCULOSIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>2 YRS. 6 MOS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>February 23, 19 57</b> to <b>February 26, 19 57</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FT. HOWARD, MARYLAND</b> DATE SIGNED <b>2/26/57</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service, Ft. Howard, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Hayes, 638 N. Gilmore St., Balto., Md.</b>				24a. REC'D BY REGISTRAR DATE <b>28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Samuel L. Fisher</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 26 1957

071

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1597 CERTIFICATE OF DEATH

01605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Convl.Home</b>		d. STREET ADDRESS <b>755 Westhills Pkwy.</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>N.</b> Last <b>Wickers</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>3,</b> Year <b>1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Guard, Savings Bank Of Balto.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Wickers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-22-5178</b>	
17. INFORMANT <b>Mrs A.L. Jaeger</b>		Address <b>755 Westhills Pkwy</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Hypertensive Cardiovascular Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>year</b> DUE TO (c) <b>year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1956</b> to <b>Feb 3, 1957</b> , that I last saw the deceased alive on <b>2-2-57</b> , and that death occurred at <b>3:48 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William L. Fearing</b>		ADDRESS (Street, city or town, state) <b>3025 Belair Road</b>	
M.D. <b>WILLIAM L. FEARING</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>EB 6 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

BUREAU V. 2

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1598

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>11 S. Woodington Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gardner Amos Wicks, Sr.</b>		4. DATE OF DEATH <b>Feb. 25/57</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1867</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glen L. Martin</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gardner Wicks</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218 09 4388</b>	
17. INFORMANT Address <b>Miss Margaret S. Wicks, 11 S. Woodington Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 4-4-57 DUE TO <b>Advanced arteriosclerotic + hypertensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular disease, with</b> DUE TO <b>myocardial degenerative.</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5 Aug., 1955</b> to <b>25 Feb., 1957</b> , that I last saw the deceased alive on <b>24 Feb., 1957</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Emil H Henning Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>601 Winans Way Balto Md</b>	
DATE SIGNED <b>27 Feb 57</b>			
PHYSICIAN'S NAME (Type) <b>EMIL H HENNING JR</b>		<b>601 WINANS WAY BALTO MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke, 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR (Type REGISTRAR'S SIGNATURE) <b>W. H. H. H. H.</b>	
		DATE <b>MAR 4 '57</b>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1599

CERTIFICATE OF DEATH

Reg. Dist. No.

016007

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd Kingsville md</u>				d. STREET ADDRESS <u>Belair Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Lydia</u> First <u>S.</u> Middle <u>Williams</u> Last				4. DATE OF DEATH <u>Feb.</u> Month <u>2</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12-1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Mast</u>				14. MOTHER'S MAIDEN NAME <u>Malinda J Bears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Emily Hagy Belair Rd Kingsville md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure - Compensated</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>56</u> , to <u>Feb.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>57</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville Md.</u>		DATE SIGNED <u>2-2-57</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahm Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>				24a. REC'D BY REGISTRAR <u>DATE 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

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BUREAU V. S.

FEB 4 1957

RECEIVED

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1600

CERTIFICATE OF DEATH

01608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>OWINGS MILLS</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEXAS - COCKEYSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BALTIMORE COUNTY HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>FEB 16 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 22, 1972</b>	
9. AGE (In years last birthday) <b>85</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM WILLIAMS</b>			
14. MOTHER'S MAIDEN NAME <b>SUSAN WINPENNY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT Address <b>Martha Ward Young - Wynnan Road - Owings Mills Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-renal disease</b> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right inguinal hernia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cockeysville, Md</b>				20g. (County) <b>Cockeysville, Md</b>		20h. (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>May 1950</b> to <b>February 1957</b> that I last saw the deceased alive on <b>February 11, 1957</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D.				DATE SIGNED <b>2/16/57</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>				ADDRESS <b>Cockeysville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Feb. 19 / 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Old Court Road Butte Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edmund A. Conner</b>				ADDRESS <b>4600 Liberty Hgts. Ave</b>		24a. REC'D BY REGISTRAR DATE <b>Feb. 16 / 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. J. Chilcoat</b>							

WILLIAM V. B.

1877

1877



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1601

CERTIFICATE OF DEATH

01609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillsdale, Maryland (Hyattsville)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1216 - 61st Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>H.</b> Last <b>Wilson, Sr.</b>		4. DATE OF DEATH <b>February 12</b> 19 <b>57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcers with hemorrhage</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 27</b> , 19 <b>57</b> , to <b>Feb. 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb. 12</b> , 19 <b>57</b> , and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-12-57</b>			
ACTUAL SIGNATURE <b>Louie Frances Woodward</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Louie Frances Woodward</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Maldison Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Seat Pleasant Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers</b>		24a. REC'D BY REGISTRAR <b>FEB 14 '57</b>	
ADDRESS <b>1400 Chapin St Wash D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Beach</b>	

BUREAU V. S.

RECEIVED  
JAN 10 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1602  
CERTIFICATE OF DEATH

01610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>		c. LENGTH OF STAY IN 1b <b>26 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stevenson Rd. Extended</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Clare</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Hood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Charles A. Wilson Jr. Stevenson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>14 4 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 56</b> , to <b>February 27, 1957</b> , that I last saw the deceased alive on <b>February 27, 1957</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Warde B. C. Allen M.D. 6 E. Egan St. Baltimore - 2 - 2/28/57</b>			
ACTUAL SIGNATURE <b>WARDE B. C. ALLEN</b> M.D. <b>WARDE B. C. ALLEN</b>			
PHYSICIAN'S NAME (Type) <b>WARDE B. C. ALLEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		24. REG'D BY REGISTRAR <b>1957</b>	
ADDRESS <b>Pikesville, Md.</b>		25. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

RECEIVED  
MAR 1 1975  
BUREAU V. S.

1603

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. NAME OF DECEASED (Type or Print) <i>Penelope Wilson</i>			2. DATE OF DEATH <i>2-6-57</i>		
3. PLACE OF DEATH A. Baltimore City B. Maryland <i>9601 Belair Rd</i>			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE B. COUNTY <i>Maryland</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Home</i>			6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore County-Rural</i>		
7. STREET ADDRESS (If rural, give location) <i>9601 Belair Road</i>			8. DATE OF BIRTH <i>June-16-1881</i>		
9. LENGTH OF STAY IN BALTIMORE <i>7 Years</i>			10. AGE (In years, last birthday) <i>75</i>		
11. SEX <i>F.</i>			12. COLOR OR RACE <i>White</i>		
13. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>			14. BIRTHPLACE (State or foreign country) <i>Henry Co Va</i>		
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			16. KIND OF BUSINESS OR INDUSTRY		
17. FATHER'S NAME <i>Morgan P. Wilson</i>			18. MOTHER'S MAIDEN NAME <i>Susan P. Wilson</i>		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			20. SOCIAL SECURITY NO. <i>no</i>		
21. INFORMANT <i>Mary Dudley</i>			22. ADDRESS <i>-9601 Belair Road</i>		
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary thrombosis</i>			24. INTERVAL BETWEEN ONSET AND DEATH		
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerotic heart disease</i>			26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
27. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II			28. DATE OF OPERATION		
29. CONDITION FOR WHICH OPERATION WAS PERFORMED			30. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
31. 21D TIME (Month) (Day) (Year) (Hour) OF INJURY			32. 21E INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
33. 21F. HOW DID INJURY OCCUR?			34. 22 I certify that (I) (this hospital) attended the deceased from <i>28 December 1956</i> to <i>6 February 1957</i> , that (I) (we) last saw the deceased alive on <i>6 February 1957</i> , and that death occurred at <i>10:30P.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>George D. Edwards</i>			23B. ADDRESS <i>M.D.</i>		
23C. DATE SIGNED			24A. REMOVAL (Specify) <i>Removal</i>		
24B. DATE <i>2-7-57</i>			24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood Home</i>		
24D. LOCATION (City, town, or county) (State) <i>Leyville M.C.</i>			25. FUNERAL DIRECTOR <i>Carl B. Whitman Funeral Home</i>		
26. DATE RECEIVED BY LOCAL REGISTRAR <i>2/11/57</i>			27. REGISTERED SIGNATURE <i>W. H. H. H.</i>		

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the Bureau of Vital Records within three (3) days after the death.

BOHANNAN V. S.

INVESTIGATIVE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>312 Henry Street</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>(NMI)</b> Last <b>WINDSOR</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/10</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orderly</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
10a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		10b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. FATHER'S NAME <b>John Windsor</b>		12. MOTHER'S MAIDEN NAME <b>Lucy MN: Unknown</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		14. SOCIAL SECURITY NO <b>220-12-0029</b>	
15. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ULCER, GASTRIC, PERFORATED</b> DUE TO (b) <b>PERITONITIS</b> DUE TO (c) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>4 DAYS</b> <b>4 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 11, 19 57</b> to <b>February 16, 19 57</b> , and that death occurred at <b>7:15 P. M.</b> on the date stated above.			
ACTUAL SIGNATURE <b>Roland D. Ponce de Leon</b>		ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>2/17/57</b>	
PHYSICIAN'S NAME (Type) <b>ROLAND D. PONCE DE LEON, M.D.</b>		Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc</b>		ADDRESS <b>6009 Harford Rd. Baltimore, Md.</b>	
24a. REC'D BY REGISTRAR <b>2-18-57</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

FEB

REAU V. S.



1441

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT</u>	
c. LENGTH OF STAY IN 1b <u>7 YRS</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3014 MARYLAND AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE WIRSCHING</u> First Middle Last		4. DATE OF DEATH <u>FEB 12</u> Month Day Year 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHT</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 1887</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF STELLHASE RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>VALENTINE WIRSCHING</u>		14. MOTHER'S MAIDEN NAME <u>KUNIGUNDE WIRSCHING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>E</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-6135</u>	
17. INFORMANT <u>MRS M. WIRSCHING</u> Address <u>3014 ME AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, right lung</u> <u>105X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio-vascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>Feb 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>57</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Delmar Laughlin</u> M.D. <u>4508 Edmondson Village</u>		DATE SIGNED <u>2/13/57</u>	
PHYSICIAN'S NAME (Type) <u>D.C. MacLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUWONT PK</u>	22d. LOCATION (City, town, or county) (State) <u>FREEDRICK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE IMBACH</u> ADDRESS <u>525 N. YAKEN HURST ST</u>		24a. REC'D BY REGISTRAR <u>RECEIVED</u> DATE <u>2-15-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>John W.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01614

1605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VERONICA</u> Middle <u>OR VERONICA</u> Last <u>FRANCES WISNIEWSKI</u>				4. DATE OF DEATH Month <u>FEBR.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-7-18</u>	
9. AGE (In years last birthday) <u>38 yrs.</u>		IF UNDER 1 YEAR Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min. <u>38</u>		IF UNDER 24 HRS. Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min. <u>38</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANCIS WISNIEWSKI</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA ZAK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-6335</u>		17. INFORMANT Address <u>Hospital records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS FAR ADVANCED</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12-2-</u> , 19 <u>53</u> , to <u>2-27-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-27-</u> , 19 <u>57</u> , and that death occurred at <u>9:40</u> A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William Newcomer</u> M.D. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D. Suot.</u> <u>Mt. Wilson, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDALK AVE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mare Fialkowski</u>				ADDRESS <u>10003 KENWOOD</u> <u>BALTO 24-MD</u>		24a. REC'D BY REGISTRAR DATE <u>2/28/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dorothy Jewell</u>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01615

1606

## CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 White Hall, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wiseburg Rd.</u>		d. STREET ADDRESS <u>1 Wiseburg Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>L.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Gemmi II</u>		14. MOTHER'S MAIDEN NAME <u>Susan Orwig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Wm. W. Wood</u>		Address <u>White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma General Abdominal</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19</u> , 19 <u>56</u> , to <u>Feb 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer Bortner</u>		ADDRESS (Street, city or town, state) <u>White Hall Md.</u>	
DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr. 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Jacob Hartenstein</u>		ADDRESS <u>New Freedom Pa.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Fulton</u>	
DATE <u>2/20/57</u>			

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BUREAU Y. S.

1697

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr7mth14dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier, Maryland</b>	
f. STREET ADDRESS <b>3402 Newton Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>O.</b> Last <b>Wood</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1889</b>
9. AGE (In years, last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>19</b> Hours <b>57</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plate printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George T. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>due to Generalized arteriosclerosis</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 7, 1957, to Feb. 16, 1957</b> , that I last saw the deceased alive on <b>Feb. 16, 1957</b> , and that death occurred at <b>1145 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLAR</b>		Address <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-20-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. RECEIVED BY REGISTRAR <b>DATE FEB 19 57</b>	
ADDRESS <b>3821-14th N.W. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. A. 07777

1951



1898

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01617

282

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr6mt26dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Mechanicsville, Maryland</b>	
f. STREET ADDRESS <b>Mechanicsville, Md.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Enss</b> Last <b>Wood</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25 ??</b>
9. AGE (In years last birthday) <b>62 1/2 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Arthur Enss</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Vascular Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>fracture right hip femur</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was pushed down by another patient, sustaining fracture of right femur</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:20 a.m. 11-2 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Catonsville 28, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George M. Kieffer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Laura Grove, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>2/4/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alan D. Hauser</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3.

FEB 6 1907

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## 1435 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>7001 Dunhill Road</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk Hereford Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>7001 Dunhill Road.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>IDA First M WORTMAN Last</b>		4. DATE OF DEATH <b>Feb. 22</b> Month Day Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30. 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Balto Co. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Louis Thompson</b>	
14. MOTHER'S MAIDEN NAME <b>Amanda Foster</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Oscar Wortman 7001 Dunhill Road. Dundalk Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Cardio-Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>104 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN 24</b> 19 <b>57</b> to <b>FEB 22</b> 19 <b>57</b> that I last saw the deceased alive on <b>FEB 20</b> 19 <b>57</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M.B. Davis</b>		ADDRESS (Street, city or town, state) <b>6800 MCKENNA RD - Dundalk Md 21222</b>	
PHYSICIAN'S NAME (Type) <b>M.B. DAVIS M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 25 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Md.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore City. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Inc. 1217 St. Paul Street Balto 2 Md</b>		24a. REC'D BY REGISTRAR <b>25 1957</b>	24b. REGISTRAR'S SIGNATURE <b>John Kelly</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1609 CERTIFICATE OF DEATH

01619  
Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bond Ave.</b>	
d. STREET ADDRESS <b>Bond Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine Yox</b>		4. DATE OF DEATH <b>Feb. 23, 1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 30, 1873</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Conrad Yox</b>		16. MOTHER'S MAIDEN NAME <b>Christine</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. ADDRESS <b>Herbert Yox, Reisterstown, Md.</b>		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLUS</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC C.V. DISEASE WITH</b> DUE TO (c) <b>AURICULAR FIBRILLATION</b>	
21. INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>		22. YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY</b> , 19 <b>48</b> , to <b>FEBRUARY 23, 1957</b> , that I last saw the deceased alive on <b>FEB. 23</b> , 19 <b>57</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		ADDRESS (Street, city or town, state) <b>48 Main St. Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel</b>		DATE SIGNED <b>2/25/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 27, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2-25-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>			

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INSTRUCTIONS

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01620

## 1610 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Baltimore</i>	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cockeysville</i>	LENGTH OF STAY (In this place) <i>Life-70 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cockeysville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Warren Rd</i>	STREET ADDRESS (If rural give location) <i>Warren Rd</i>		
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Benjamin Clark</i>		<b>4. DATE OF DEATH</b> (Month) <i>February</i> (Day) <i>15</i> (Year) <i>1957</i>	
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>17 March 1886</i>
		<b>9. AGE last birthday</b> <i>70</i> yrs.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Blacksmith</i>
		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Cockeysville, Balto Co. Md</i>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>
<b>13. FATHER'S NAME</b> <i>George Zink</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Ellen (Nellie) Clark</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or link.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>214-03-2976</i>	
		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mildred Mangovan - Same</i>	
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>4. IMMEDIATE CAUSE (A)</b> <i>Arterio-sclerotic cardio-vascular disease</i>			<i>10 yrs</i>
<b>5. ANTECEDENT CAUSE(S) DUE TO (B)</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <i>Chronic Bronchitis &amp; Emphysema</i>			<i>over 10 yrs</i>
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>	<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>	<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <i>1946</i> to <i>Feb 15</i>, 19<i>57</i>, that I last saw the deceased alive on <i>14 Feb</i>, 19<i>57</i>, and that death occurred at <i>7:30 AM</i>, from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>Robert T. Kees</i>		<b>DATE SIGNED</b> <i>Cockeysville Md 15 February 1957</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>	<b>DATE THEREOF</b> <i>2-18-57</i>	<b>NAME OF CEMETERY OR CREMATORY</b> <i>Sherwood</i>	<b>LOCATION (City, town, or county) (State)</b> <i>Cockeysville, Md</i>
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b> <i>Al L. Smith</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Frank H. Jewell</i>	<b>ADDRESS</b> <i>Baltimore</i>
<b>DATE</b> <i>FEB 19 57</i>			

U.S. A.

1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1718 Holbrook Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Solomon</b> Middle <b>Zinser</b> Last <b>Zinser</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Adolph Zinser</b>		14. MOTHER'S MAIDEN NAME <b>Clementin Zinser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>220-09-4526</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 3</b> , 19 <b>57</b> , to <b>Feb. 4</b> , 19 <b>57</b> that I last saw the deceased alive on <b>Feb. 4</b> , 19 <b>57</b> , and that death occurred at <b>3:50 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Gertrude J. Fleischmann, M. D.</b>		PHYSICIAN'S NAME (Type) <b>Gertrude Fleischmann, M. D.</b> <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/7/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balt.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 5 57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Signature of Reporter	

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FEB 6 1937

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1612 CERTIFICATE OF DEATH

016238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Baltimore</u> STATE <u>Maryland</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>427 Hopkins Rd.</u>		d. STREET ADDRESS <u>427 Hopkins Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>L.</u> Last <u>Zupnik</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine Surgery</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Zupnik</u>		14. MOTHER'S MAIDEN NAME <u>Annie Rudolph</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs Katherine Zupnik, 427 Hopkins Rd, Balto 12 Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Cerebral Paralysis</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Toxins</u> (c) <u>Hypertension of Kidney</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>10 hrs</u> <u>5 mos 7</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Feb 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-15-</u> , 19 <u>57</u> , and that death occurred at <u>8 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Demarco Jr</u>		DATE SIGNED <u>2-15-57</u>	
PHYSICIAN'S NAME (Type) <u>S. Demarco Jr.</u>		<u>715 N. Charles St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Febr. 19 1957</u>	<u>New Freedom Cem.</u>	<u>New Freedom, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Horstenstein</u>		24a. REC'D BY REGISTRAR <u>B 19 1957</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Grange</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

FILE

BUREAU V. S.

FEB 19 1957

RECEIVED